Derbyshire Community Health Services NHS Foundation Trust

RY8

Community dental services

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
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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)
RY846	Ilkeston Hospital	Community Dental Services	DE7 8LN

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

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

Where applicable, we have reported on each core service provided by Derbyshire Community Health Services NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Community Health Services NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated the community dental services at this trust as outstanding.

- Staff protected patients from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.
- Infection control procedures were in place. The environment and equipment were visibly clean and well maintained and medicines and emergency equipment was available at each site we visited.
- The dental services were effective and focused on patients and their oral health care.
- We found clinical staff delivered care according to best practice guidelines for dentistry; this included special care dentistry, conscious sedation for dentistry in primary care, paediatric dentistry and preventive dental care.
- Patients, relatives and carers said they had positive experiences of care within the service. We saw good examples of staff providing compassionate and effective care. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed their dedication to what they did.
- Staff responded to patients' needs at each clinic we visited. The service kept treatment delays for routine and complex dental treatment within reasonable limits through effective resource management.
- The community dental service was well led. Organisational, governance and risk management structures were in place. The service's operational management team was visible and the working culture appeared open and transparent. Staff were aware of the organisation's vision and way forward and they said they felt well supported and they could raise any concerns.
- The service vision and strategy was an evolving one. This was because the service was being placed out for tender in the coming months which had brought a period of uncertainty. Despite this, we spoke to dentists and dental nurses who said the service had forward thinking and proactive clinical directors who were well supported by senior managers within the trust.
- The culture of the service was one of continuous learning and improvement. At each clinic we visited, we saw staff worked well together and there was respect between all members of the dental team.
- The morale of the staff appeared good at each clinic with staff adopting a positive 'can do' philosophy about their practice and the challenges they faced.

Summary of findings

Background to the service

Derbyshire Community Health Services provides dental services in community dental clinics spread across Leicestershire and Derbyshire. In addition to the clinics the clinics the service uses two acute hospitals in Leicester and Derby to deliver dental services for patients of all ages who required general anaesthesia which is not available in community clinics or general dental practices. The service includes oral health care and dental treatment provision for patients with impairments, disabilities and/or complex medical conditions. This provision extends to patients with physical, sensory, intellectual, mental, medical, emotional or social impairments or disabilities including those who are housebound and homeless. The dental service in Leicester and Coleman Street provided urgent care dental services for patients unable to access a NHS high street dental practice through a dental access centre. The service also undertook domiciliary (home) visits for those patients who were house bound.

The service offers conscious sedation in selected clinics when treatment under local anaesthetic alone is not feasible. The service provides general anaesthesia (GA) as necessary for the very young, the extremely nervous, patients with special needs and patients who need multiple extractions.

During our inspection we visited six community dental service locations:

- Loughborough Health Centre
- Leicester Dental Acess Centre
- Swadlincote Health Centre
- Coleman Street Health Centre
- Long Eaton Health Centre
- Ilkeston Hospital

During our inspection we spoke with a range of individuals includings senior managers, lead clinician, senior nurses, seven dentists, ten dental nurses, two decontamination technicians, two receptionists, five carers and four patients.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

We inspected this service in May 2016 as part of the comprehensive inspection programme.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 23 to 25 May 2016.

What people who use the provider say

All of the people we spoke with during the inspection, without exception, were very positive about the dental services provided. This included patients, family members accompanying patients and carers. Comments included –

I don't know what we would do without this service as my general dental practitioner does not have the facilities to cater for those with special needs.

The dentists and nurses are lovely.

I have to come here because I do not have an NHS dentist, it can be difficult to get an appointment but they are always helpful.

Good practice

- We found clinical staff delivered care over and above best practice guidelines in relation to dentistry; this included adaptations to provide individualised special care dentistry, conscious sedation dentistry in primary care, paediatric dentistry and preventive dental care through detailed patient assessment and individualised treatment plans which took into consideration each patient's specific dental and special care needs.
- Staff adopted an holistic approach concentrating fundamentally on the patient's social, physical and medical needs first, rather than seeing patients as a collection of signs and symptoms that required a mechanistic solution to their dental problems.
- We observed several treatment sessions across the service and saw how the dentists built and maintained respectful and trusting relationships with patients and carers.
- A senior nurse was involved in dental nurse training at local and national level and the service welcomed student dentists and nurses into clinics for the practical element of their training. This was validated by educational establishments arranging placements for their students and therefore supported the continual development of the service as a learning environment.
- Dental staff worked with the patient experience team to develop a 'Fluffy Bear' version of the family and friends card. This enabled patients to provide feedback in pictorial format.
- Senior clinicians and nurses contributed to local undergraduate and postgraduate teaching programmes for dentists, dental hygiene therapy and dental nursing by providing community teaching services.
- The service coordinated treatment input for patients living with special needs who were undergoing general anaesthesia. This included podiatry, venepuncture and other interventions which would be distressing to the patient. This also reduced the number of health care attendances required by patients.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The community dental service should consider how to improve communication between the Derbyshire and Leicestershire based clinics.
- The community dental service should consider how they can collect and demonstate evidence of patient outcomes.
- The community dental service should consider how they can gather data to evaluate the impact of capacity limitations for dental access clinics.

Derbyshire Community Health Services NHS Foundation Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safety of the community dental service as good because:

- The dental service used the trust electronic incident reporting system to identify, investigate and learn from patient safety incidents.
- Staffing levels were safe in the clinics across the whole service.
- Dental radiography was carried out at each of the locations we visited by staff with additional training in dental radiography. Radiology equipment was maintained by technicians from the Derbyshire Community Health Service (DCHS)Foundation Trust.
- Infection prevention and control practices represented best practice and equipment used to process contaminated instruments was maintained in accordance with national guidelines.
- Equipment and medicines available for medical emergencies were maintained in accordance with Resuscitation Council and British National Formulary guidelines.
- X-ray equipment was maintained according to recognised safety guidelines.
- Dental service staff received adult and children safeguarding training and were confident in their knowledge of how to escalate concerns.
- Staff informed other professionals when children missed clinic appointments in order to identify potential risks in relation to safeguarding concerns.
- We found that dentists carried out conscious sedation in accordance with the new guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists April 2015.

Incident reporting, learning and improvement

- There had been no 'never events' in the Derbyshire Community Health Services (DCHS) dental service reported for the year April 2015 to March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. An example of a never event in dentistry is a wrong tooth extraction.
- DCHS dental service reported incidents using the trust electronic reporting system. Staff we spoke with demonstrated to us how the system worked. The system appeared easy to use and staff reported they received acknowledgment emails following submission of an

incident. Incidents were shared with staff through regular staff meetings to facilitate learning. We saw evidence of this within staff meeting minutes. The most common incidents reported included patient violence or difficult behaviour and when patients did not arrive (DNA) at clinic.

- We saw examples of staff meeting minutes from April 2016 demonstrating where incidents had been discussed to facilitate shared learning. There were also standing agenda items relating to equipment, health and safety alerts, risk management issues and clinical audit.
- We saw evidence of a rolling programme of audits to monitor safety performance. These included infection control, X-ray quality and processing, antibiotic prescribing and patient record keeping. We were shown completed audits for 2015-16, for these topics.
- Staff we spoke with were familiar with the term 'Duty of Candour,' explaining to us the principle of being open and honest when things go wrong. The duty of candour is a regulatory duty that relates to openness and transparency and 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.

Safeguarding

- Staff we spoke with were aware of the trust's safeguarding policy and had received training appropriate to their clinical grade. The level of child safeguarding training received by all staff including medical and nursing staff was Level Two. Safeguarding has three levels of training; level one for non-clinical staff, level two for clinical staff and level three for staff working directly with children and young people.
- All staff had received training in adult safeguarding and the Mental Capacity Act.
- The dental service had access to the DCHS safeguarding team for advice and guidance.
- Mandatory training records demonstrated 100% of staff working within the community dental service had received safeguarding training.
- Staff were knowledgeable about safeguarding issues in relation to the community they served and were able to quote examples of how and when they would escalate a concern. Examples provided included suspected domestic abuse, repeated child non-attendance to clinic and suspected people trafficking. Staff reported positive feedback from the relevant authorities about the safeguarding reports they had submitted.
- All of the dentists we spoke with were aware of how safeguarding concerns could affect the delivery of dental care. This included children who presented with high levels of dental decay, which may indicate a child is suffering from neglect.
- Children who repeatedly did not attend for treatment were identified on the electronic patient system and referred to their school nurse,social worker or safeguarding for follow-up.

Medicines

- Medicines management for medical emergencies in primary dental care was in line with the guidance set out in the British National Formulary (BNF). Medicines were available at all times, in date and stored correctly. Where medicines required refridgerator storage a daily log of temperature was mainitained.
- Unused or out of date medicines were returned to the pharmacy for disposal.
- Dental nurses used a checklist for monitoring the expiry dates of emergency medicines at each clinic. We saw systems in place at each clinic where the responsible dental nurse at each location signed to validate this checklist.
- At each clinic visited there was a comprehensive system for recording all prescribed medicines and the FP10 (Prescription pads) were stored in locked cupboards with each prescription number recorded by patient number.
- Local anaesthetics, antibiotics and high concentration fluoride toothpastes were prescribed according to current clinical guidelines. Prescriptions were recorded in patient's records.

Environment and equipment

- All of the clinics visited appeared visibly clean, tidy and free from unnecessary clutter. This meant access was obstruction free promoting staff and patient safety.
- Dental equipment at each site appeared to be clean with maintenance schedules kept up to date. For example, autoclave (sterilising) equipment was serviced every three months. We reviewed maintenance records for equipment and found them to have been consistently maintained.

Good

Are services safe?

- At each site visited we found equipment used for cleaning and sterilising contaminated dental instruments was validated, serviced and calibrated in line with the guidance set out in the Health Technical Memorandum (HTM) 01 05 Decontamination in Primary Dental Care.
- Radiology equipment was serviced and maintained by radiation protection advisors and medical physics technicians from two local acute hospitals trusts.
- Equipment for managing medical emergencies in the primary care dental setting was readily available on each site visited; this included an Automated External Defibrillator, oxygen and associated breathing aids. This was in line with the Resuscitation UK and BNF guidelines.
- We saw appropriate management of clinical waste, which was segregated, labelled and disposed of in accordance with good practice. For example, boxes for the disposal of sharps (needles etc.) were dated and disposed of by the recommended use by date, in accordance with the European Union directive for the safe use of sharps.
- At each site, we saw a well maintained radiation protection file. This contained all the necessary documentation relating to the safe use of X-ray equipment. This is in accordance with national regulations pertaining to ionising radiation.
- The community dental service ensured all X-ray sets were serviced and calibrated according to the recommendations set out in the Ionising Radiation Regulations 1999. We saw service records for each X-ray set in the clinics visited, indicating they were safe for use.
- Dental X-rays, when prescribed, were justified, reported and quality assured on each occasion. We saw dental records that confirmed this was the case. This meant the community dental service was acting in accordance with national radiological guidelines and protected staff and patients from receiving unnecessary exposure to radiation.
- Domiciliary dental checks were carried out if it was not possible for a patient to attend a clinic.Domiciliary treatment included dental assessment however any intervention beyond cleaning or application of fluride protective paste was subsequently arranged to take place at an appropriate clinic or hospital.

Quality of records

- The individual patient records were a mix of computerised and paper records. There were some differences in the electronic patient record systems use in Derbyshire and Leicestershire although the two areas were able to share information.
- Clinical records were kept securely so that confidential information was properly protected. Information such as written medical histories, referral letters and dental radiographs were collated in individual patient files and archived in locked and secured cabinets not accessible to the public in accordance with data protection requirements. Computerised records were password protected. These precautions were applicable to all clinics visited.
- We reviewed a sample of three sets of records at each location visited and found they were updated by each dentist and provided comprehensive information on the individual needs of patients such as; oral examinations, medical history, consent and treatment plans.
- All of the clinical records we viewed were clear, concise and accurate providing a detailed account of the treatment patients received. Dental staff recorded patient safety and safeguarding alertssuch as an allergy to antibiotics.
- We saw patient risks were included in all patient records reviewed and an audit of patient record keeping was being undertaken at the time of our visit.

Cleanliness, infection control and hygiene

- All of the clinics we visited were visibly clean and tidy and there were clearly defined roles and responsibilities for cleaning and equipment decontamination at each location.
- Named staff carried out local decontamination of dental instruments and equipment. The service met best practice HTM 01 05 (guidelines for decontamination and infection control in primary dental care). This was achieved by the use of a separate decontamination room, the use of automated washer disinfectors for the initial cleaning of instruments and a separate storage area for decontaminated instruments.
- At each of the Derbyshire clinics, a named decontamination technician was employed to carry out the cleaning, sterilisation and packaging of dental instruments. In Leicester dental nurses carried out this process.
- Staff at each clinic we visited demonstrated the arrangements for infection control and

decontamination procedures. They were able to demonstrate and explain in detail the procedures for cleaning the dental equipment, transferring and processing dirty instruments through the designated decontamination rooms and the safe storage of clean instruments. We saw recorded evidence of equipment being used within the timescales stipulated in HTM 01 05.

- We reviewed the documentation of daily, weekly and quarterly test sheets for the equipment used in decontamination of dental equipment. This included autoclaves and the washer disinfector.
- We observed good infection prevention and control practices in the clinics visited. 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 (PPE), such as gloves and aprons, whilst delivering care and treatment. We observed appropriate disposal of PPE.
- We found cleaning schedules were in place and displayed for each individual treatment room. The responsible dental nurse at each clinic had signed off each schedule.
- There were infection prevention and control audits for each location at regular intervals during 2015-16. The results of these audits were displayed and showed levels of compliance of between 95 to 100%.
- Infection Prevention Society Audits were carried out twice yearly in accordance with HTM 01 05 guidelines. A scheduled audit was planned at the time of our visit; we were shown the documentation to support this. Previous audit November 2015 – results were infection prevention and control 95% to 100%, decontamination 97% to 100% and environment 79% to 100%. Target for compliance was 100%. Environment issues identified included clutter in clinical room and dust in ventilation grills; these had been discussed with staff at the time of the audit or escalated to the relevant department.

Mandatory training

- Staff in the community dental service told us they had good access to mandatory training study days.
- Mandatory training for staff included infection prevention and control, manual handling, fire, information governance, life support (adult and child), safeguarding for vulnerable adults and children and the management of emergencies in the dental chair.
- We reviewed the service log for mandatory training and saw recorded evidence, which confirmed all 100% of staff working in the community dental service had attended the required mandatory training, or were booked to do so. The service managers were diligent in their management of staff in relation to mandatory training and ensured staff achieved the trust targets.
- Staff compliance with mandatory training was reviewed at their annual appraisal.

Assessing and responding to patient risk

- During our inspection, we looked at a sample of three dental treatment records at each location. We found dental staff recorded patient safety alerts. For example, medical histories were taken by dentists and updated when patients attended for dental treatment. These medical histories included allergies and reactions to medication such as antibiotics.
- Six dentists told us they had adequate time to carry out assessments and consider any risks prior to providing clinical care for their patients. They had sufficient clinical freedom to adjust time slots to take into account the complexities of the patient's medical, physical, psychological and social needs.
- Staff ensured patients and carers received appropriate post-operative instructions following dental surgery. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage and infections.
- A quality check list was used when patients were to undergo a procedure. We observed this checklist used at a pre-operative assessment appointment. The check included patient's identity, pertinent medical history and record of informed consent. The checklist also included assessment of dental radiographs and treatment planning for theatre time.
- The quality check list included a post-operative check specific to dental treatment. For example, counting the number of cotton wool rolls, green gauze, mouth prop and extracted teeth. The number of each item would be recorded and countersigned by the dentist. This demonstrates use of a modified world health organisation (WHO) safe surgery checklist.

Good

Are services safe?

- We observed the use of white boards in addition to the check list which recorded all checks. The responsibility for checking each white board was delegated to two members of the dental team. Post-operatively the checklist would be completed to ensure verbal and written instructions had been provided, transport arrangements were in place, analgesia prescribed, dietary advice given, treatment provided confirmed, clinical records completed and discharge letter provided**.**
- Patients with special needs had specific physical, social and psychological risks, these were discussed with carers and responded to on an individual basis. For example, a patient had difficulty attending for treatment due to accessing the department through sliding doors. This was a risk to the patient's psychological health and therefore alternative entry arrangements were made to mitigate this risk. Additionally all patients with special needs were seen in the presence of a relative or carer.
- There were clear records recording daily checks to monitor the safety of x-ray equipment to ensure patient and staff safety. This included radiation exposure check discs worn by staff carrying out x-rays.

Staffing levels and caseload

- Staffing levels at each location were appropriate and we found teams worked well together. Planned clinics had one dentist and one nurse present at all time.
- There was an electronic staff rota in place through which managers could plan and monitor clinic coverage. Nurses provided cover to clinics other than their own regular clinc during annual leave and sickness and would travel between local clinics if required to do so. Dentists provided cover for each other during planned leave.
- There were no vacancies reported and no use of agency nurses.
- The appointment diaries at each location we visited showed appropriate staffing levels for all appointment slots and cover for the out of hours nurse telephone triage (assessment of urgent care need).

Managing anticipated risks

- We found dentists carried out conscious sedation in accordance with the new faculty guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists April 2015. We saw clinical records of two patients , which clearly identified the dentist had checked medical history, ability to breathe through the nose, time of last meal and availability of an escort for returning home.
- We found the community dental service had robust governance systems to underpin the provision of conscious sedation. The systems and processes we observed were in accordance with the guidelines.
- We reviewed governance systems and saw policies and protocols to mitigate patient risk. These included pre and post sedation checks, emergency equipment requirements and medicines management. Dentists and dental nurses carried out and recorded additional safety checks, which included equipment, records of personnel present and confirmation of post-operative instructions provided to patients.
- Patients were appropriately assessed for sedation. We saw dental treatment records showed all patients undergoing sedation had checks by the dentists prior to sedation. These include medical history and assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.
- We saw clinical records, which demonstrated important checks were recorded at regular intervals whilst a patient was sedated. We saw pulse, blood pressure, breathing rates and oxygen saturation were recorded. Dental staff used a pulse oximeter to measure the patient's heart rate and oxygen saturation (this is a piece of equipment placed on the patient's finger).
- We saw two appropriately trained nurses supported dentists carrying out intra-venous sedation. This was recorded in the dental care records with details of their names. The measures in place ensured patients were being treated in line with current standards of clinical practice.
- The service had a named Radiation Protection Adviser and Radiation Protection Supervisors ensuring the service complied with their legal obligations. Ionising Radiations Regulations 1999 (IRR99) are a statutory legal requirement for the use and control of ionising radiation in the United Kingdom.
- Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were in place. This is a reporting mechanism published by the Department of Health, September

Good

Are services safe?

2012 with regard to radiation exposures much greater than intended and diagnostic reference levels. There had been no IRMER reports submitted in the last 12 months for the community dental service.

- We saw when dentists took X-rays they were recorded as justified, reported on and quality assured every time in accordance with national radiological guidelines. We saw dental records that confirmed this was the case.
- All health and safety policies and procedures were available and accessed through the trust's intranet.
- Each location had a well-maintained control of substances hazardous to health (COSHH) file in accordance with the COSHH regulations.
- Managers and staff told us, an emerging risk was the increasing demand on the service. Activity was being reported to the clinical commissioning groups to reflect this increased activity.

Outstanding ☆

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.

We rated the community dental service as outstanding for effective because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to people who were referred into the community dental service. Staff used innovative approaches to provide individualised care to those living with special needs.
- Clinical staff delivered care according to best practice guidelines for dentistry; this included special care dentistry, conscious sedation for dentistry in primary care, paediatric dentistry and preventive dental care.
- Systems were in place to manage and share information in order to coordinate care which met individual circumstances and preferences.
- All staff received professional development appropriate to their role and learning needs. Continual professional development was supported, encouraged and recognised as being integral to ensuring high quality care.
- Staff, registered with the General Dental Council (GDC), had frequent professional development (CPD) and clinical supervision which met their professional registration requirements.
- Dental staff used the Department of Health Delivering Better Oral Health Toolkit 2014 when providing preventative advice to patients on how to maintain a healthy mouth. This was an evidence based tool kit used for the prevention of the common dental diseases.
- Dentists working in the community dental service had additional postgraduate qualifications enabling them to deliver dental care to an increasingly complex cohort of patients.
- The community dental service placed great emphasis on the benefit of secondary training for dental nurses. This included care of the conscious sedated patient, intravenous sedation and radiology in dentistry.

Evidence based care and treatment

- Community dental services provided care which followed approved national guidance such as the National Institute for Health and Care Excellence (NICE), specialist dental societies and other relevant professional groups. Dentists, therapists and dental nurses working in the service used various national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health and the Faculty of General Dental Practice. Dentists and dental nurses we spoke with were fully conversant with these guidelines and the standards that underpinned them.
- Lead clinicians were assigned across the service to ensure best practice guidelines were implemented and maintained. This included lead clinicians in conscious sedation, special care dentistry and paediatric dentistry.
- The service delivered dental general anaesthesia (GA) and conscious sedation services according to the standards set out by the dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists Standards for Conscious Sedation in the Provision of Dental Care 2015.
- Special Care Dentistry for patients with complex medical and mental health and social impairments was delivered according to best practice as set out by the British Society for Disability and Oral Health (BSDH); this included domiciliary care.
- Policies we reviewed reflected national guidance with appropriate evidence and references. Staff we spoke with could direct us to these policies.
- We observed patients and carers being provided with clear verbal and written instruction following treatment. For example the avoidance of drinking or eating for half an hour after fluoride treatment reflected best practice.
- Dental staff used the Department of HealthDelivering Better Oral Health Toolkit 2014 when providing preventative advice to patients on how to maintain a healthy mouth. This was an evidence based tool kit used for the prevention of common dental diseases.
- The dental records of consultations observed, during the inspection, included clear plans of care, which reflected best practice, including the record of discussions with patients and carers about planned treatments and oral health.

Pain relief

Outstanding ☆

Are services effective?

- Dentists assessed patients appropriately for pain and other urgent symptoms. For example, in cases of very young children where local anaesthesia would not be tolerated for a tooth extraction, general anaesthesia, under the care of a hospital anaesthetist, was provided as an alternative.
- Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures such as dental fillings and extractions. In the dental access centres at Coleman Street and Nelson Street we observed two patients receive effective relief of dental pain.
- Patients contacting the dental access clinics (DAC) by telephone were assessed by a qualified dental nurse using a series of questions. This included how long since onset of pain, severity of pain, sensitivity to pressure and the presence of any facial swelling. Appropriate advice for pain relief was then provided. We observed two calls received by a DAC when information was gathered about the caller's medical history and current medication status prior to providing advice about taking any further medication to relieve the pain. Other comfort strategies were given to the caller to help them whilst waiting to see a dentist.

Nutrition and hydration

- Children and adults having procedures under GA were appropriately advised by dentists on the need to fast, no food or drink,before undergoing their procedure. Patients undergoing conscious sedation also received appropriate advice from dentists and dental nurses regarding eating before their procedure.
- We saw examples of patient information leaflets detailing nutrition and hydration advice that had been developed by dental staff. These included written and pictorial representations, which were appealing to adults and children.
- There were posters and information relating to diet available in all the clinics we visited.
- We observed dentists providing advice about healthy diets during consultations. This included talking to parents and carers about providing sugar free drink options for children and avoiding the use of bottles for toddlers and older children.

Patient outcomes

- Community dental services provided care to patients with special needs which general dental practices were unable to accommodate. These patients remain with the service long term.
- Patients attending the dental access centres (DAC) for emergency care, out of normal general dental practice hours or because they are not registered at a general dental practice received urgent care only. Follow-up treatment was provided by the patient's own dentist or assistance provided to the patient to find a local dentist for continuing treatment.
- We saw audits of patient treatment, which included actions for improvement. For example, a dental antibiotic prescription audit (2015). Findings indicated 82% of antibiotics prescribed were appropriate. An action plan was in place to address the 18% inappropriate antibiotic prescribing which included a repeat audit.
- The dental service participated in audits in support of other specialities. For example a frozen shoulder audit completed for the outpatient physiotherapy team. This showed good local identification of the condition and pain management but limited documentation.
- Patient information was recorded at each visit using a series of questions within the electronic patient record system to identify each patient's dependency. This enabled the service to plan an appropriate time allocation for patients with special needs and therefore facilitate the best outcomes for these patients.
- We found patients were appropriately assessed for all treatments and outcomes of consultations and treatment was recorded. We witnessed clinical records being completed at each clinic observed.
- Patients with special needs received dental surveillance and therefore remained within the service for regular assessment and treatment as required.

Competent staff

- The service encouraged staff to undertake additional professional training to manage the increasing complexity of patients.
- We found dentists working in the dental service had taken additional postgraduate qualifications enabling them to deliver dental care to an increasingly complex cohort of patients. This included postgraduate masters degrees and diplomas in special care dentistry and paediatric dentistry and some dentists were on the

General Dental Councils (GDC) specialist register. This means if a denist holds full GDC registration and has completed a specialist training programme approved by the GDC they can apply for the award of a certificate of completion of specialist training (CCST) and entry onto a specialist list of dental practitioners.

- To complement the specialist dentists, the community dental service placed great emphasis on the benefit of using extended duty dental nurses. We found dental nurses across the service had additional diploma level training in conscious sedation, general anaesthesia in dentistry, dental radiography and oral health promotion.
- A senior nurse was involved in dental nurse training at local and national level and the service welcomed student dentists and nurses into clinics for the practical element of their training. This was validated by the educational establishments arranging placements for their students and therefore supported the continual development of the service as a learning environment. We were provided with evidence from the National Examining Board for Dental Nurses of certificated accreditation for special care dental nursing, dental sedation nursing, dental radiography and dental sedation nursing.
- The six senior dental nurses had specialist training who had responsibility for intravenous sedation, general anaesthesia, oral hygiene and the dental access centres.
- All staff had received regular annual appraisal. Records showed all staff had received their annual appraisal for the year 2015 to 2016 with the exception of staff on long term sick. Staff were positive about their appraisal stating they had clear objectives and follow up one to one meetings with their managers. One member of staff shared their appraisal file with an inspector as an example of how appraisals are documented and objectives clearly set.
- All staff undertook yearly training in cardiopulmonary resuscitation appropriate to their clinical grade. For example, 100% of staff involved in providing intravenous sedation, relative analgesia sedation (relative analgesia is inhalation sedation of nitrous oxide ("laughing gas") and oxygen) or general anaesthesia undertook training in Intermediate Life Support Techniques for both adults and children. This was in accordance with new guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.
- Each clinic had a technician, trained in decontamination, who was responsible for all instrument decontamination.

Multi-disciplinary working and coordinated care pathways

- There was effective and collaborative working across all disciplines involved in patient's care and treatment. For example, if a patients presented with complex medical conditions there was consultation between the patient's GP or hospital consultant, the dentist and other health care professionals involved in the patients care to determine the most appropriate treatment. We saw examples of this in the medical records of patients with complex needs.
- We found there were coordinated hospital theatre sessions for patients with severe learning disabilities. During these sessions, patients were able to receive various speciality care or treatment such as dentistry, podiatry, orthopaedics and phlebotomy whilst under anaesthesia. This meant patients did not need to make several hospital visits for distressing procedures.
- The service maintained close working relationships with the health visiting and learning disability teams to ensure vulnerable groups requiring dental care could gain access to treatment and care easily.
- We found for example that patients referred into the dental service for dental anxiety and phobia entered an anxiety pathway. This pathway began with an assessment of the patient's dental anxiety. Following initial assessment, patients were offered a variety of options; this included oral, inhalation and or intravenous sedation. We saw examples of the anxiety assessment form and documented action plans which included the identification of various health professionals needed to support anxious individuals requiring dental treatment.
- Dentists within both Derbyshire and Leicestershire areas of the community dentist service had representation on the managed clinical network (MCN) for Special Care Dentistry. An aim of the MCN for Special Care Dentistry was to engage with local general dental practitioners so they could work alongside each other in the provision of shared care for patients with a variety of special needs. This would enable general dental practitioners to treat patients with mild to moderate levels of special needs whilst having experienced clinicians from the service providing advice and expertise where necessary. This

approach would enable the upskilling of general dental practitioners which in turn would lead to better patient outcomes. This shared care enabled the service to respond appropriately to patient need, disease levels in the community and demographic changes by concentrating on those patients with the highest and most complex need.

Referral, transfer, discharge and transition

- There were clear systems and processes in place for referring patients into the community dental service. The service and commissioners had developed systematic processes to ensure efficient use of NHS dental resources.
- Patients were seen by the dental service for single courses of treatment requiring sedation or general anaesthesia. After treatment, patients were discharged to their referring general dental practitioner (GDP). A discharge letter detailing the treatment carried out by the service and any further intervention required was provided for the GDP and a copy given to the patient or carer.
- Patients with special needs were offered continuing care to ensure their oral and dental health needs were monitored regularly.
- Patients not registered with a dentist, attending for emergency treatment where given information and advice about registering with an NHS dentist.
- Protocols were in place describing how patients were discharged from the service following general anaesthesia, intra-venous or relative analgesia sedation. Protocols we saw clearly demonstrated patients were discharged in an appropriate, safe and timely manner.
- We were shown the discharge process that staff followed to make sure the patient or responsible adult had a set of written post-operative instructions and understood them fully following intra-venous sedation. Patients and their carers were given contact details if they required urgent advice and or treatment. The service had developed bespoke patient information leaflets that detailed these instructions. We saw several sets of patient records that confirmed that this system was in operation.

Access to information

- Information relating to best practice and guidance for information governance management was provided through mandatory training and trust policies located on the trust intranet.
- Staff had access to a trust You Tube account where information and news was shared. This could be accessed from home.
- Patients had access to a variety of information about their dental treatment in leaflet form. This information included pre and post-operative instructions and advice to help them manage their dental care effectively before, during and after any treatment received.
- All the clinics we visited displayed information about the NHS charges for the treatment patients may receive and dental health promotion information.
- Staff had access to patient records through the electronic patient record system. Access was password protected. Records were updated by dentists and dental nurses directly after each consultation.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. Training records reviewed confirmed 100% of staff had received mandatory training in consent, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).
- Staff we spoke with, at all locations, understood the legal requirements of the Mental Capacity Act 2005 and they had access to social workers and staff trained in working with vulnerable patients. This included safeguarding leads and learning disability nurses.
- There was a robust system for obtaining consent for patients undergoing General Anaesthesia, conscious sedation and routine dental treatment.
- The consent documentation used in each case of general anaesthesia and conscious sedation consisted of the referral letter from the general dental practitioner or other health care professional, the clinical assessment including a complete written medical, drug and social history. Full and complete NHS consent forms were used by each dentist as appropriate in every case during the consent process.
- We reviewed ten patient records, which demonstrated the systems, and processes for obtaining consent by dentists were completed.

Outstanding ☆

Are services effective?

- Where adults or children lacked the capacity to make their own decisions staff made decisions about care and treatment in the best interests of the patient. To do this the patient's representatives and other healthcare professionals were involved in the decision making process. All decisions and rationale were documented in the patient records.
- Young people were involved in treatment decisions, wherever possible. None of the patients we saw receiving treatment were within this category however, full explanations were given prior to any treatment of examination.

Outstanding ☆

Are services caring?

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

We rated the community dental service as outstanding for caring because:

- Patients and carers, without exception, told us they had positive experiences within the community dental service. People told us staff go the extra mile and adapted their approach in orderto provide care and treatment to patients living with special needs.
- We found staff did everything they could to ensure patients and their carers had a positive experience whilst in the care of the dental teams.There was determination and creativity to overcome obsticles to delivering care.
- Patients, families and carers felt supported and involved with treatment plans and staff displayed compassion, kindness and respect at all times.
- We found all staff from receptionist to senior dental practitioners to be hard working and committed to the care and treatment they provided.
- Staff spoke with passion about their work and conveyed their dedication to what they did.
- We observed treatment sessions in all of the locations visited and saw how the dentists built and maintained respectful and trusting relationships with patients and their parents and carers.

Compassionate care

- During our inspection, we spoke with patients and their carers at the clinics visited to gain an understanding of their experiences of care. They said they were happy with the care and support provided and told us the staff went out of their way to meet their different needs when attending the clinics, this included adapting the environment to facilitate treatment in a patients own chair and utilising diversional therapies such as rotating ceiling pictures and aromatherapy.
- We observed staff treating patients with dignity and respect. We heard and observed staff using language that was appropriate to patients' age or level of understanding. They used previous attendance notes and patient knowledge to communicate in a manner, which met the individual's needs. Nurses and dentists spoke clearly to patients and used respectful touch to reassure individuals when needed. Personal dignity was maintained at all times, ensuring doors were closed to prevent others entering.
- During the inspection we were particularly impressed by the interpersonal skills displayed by all the staff working within the service.
- Dentists and nurses spent time preparing in advance for their patients with special needs.This included reading previous records, in which specific individual needs had been recorded and discussing specific strategies to enable a successful consultation. This meant examinations and procedures could be carried out quickly and efficiently, reducing stress and anxiety for patients.
- Staff were particularly considerate of patient's anxieties providing them with constant reassurances and clear explanations about their treatment. Staff allowed patien's time to respond if they were not happy or in pain.
- Staff showed high levels of compassion towards patients in order to make their visit as pleasant as possible. For example, one patient with a fear of sliding doors who could not enter the clinic by the main entrance was assisted to gain access by an alternative route.
- Patients contacting the dental access clinics (DAC) for emergency dental treatment were spoken to in a way which displayed empathy and concern for their distress. One patient attending for emergency treatment told us he was desperate for pain relief and the clinic staff had been very helpful, putting him at ease.
- Nurses undertaking telephone triage (telephone assessment) of patients contacting the DAC for emergency care were occasionally subject to verbal abuse. However, they had strategies for dealing with these callers in a respectful and caring way. Staff told us patients in pain can be frustrated, they were aware of this and tried to help them through their difficulty. Continued abuse was reported as an incident using the electronic reporting system.
- Compassionate care was provided equally to adults, young people and children. We observed one child arriving for a consultation, he and his parents were

welcomed into the examination room in a friendly way and all the family was involved in discussions about oral heigene and how they could make lifestyle changes to improve the child and families oral health.
- Community dental services were available to all patients referred irrespective of their race, religious or cultural beliefs. There was no evidence of discrimination with referral criteria being fully inclusive.

Understanding and involvement of patients and those close to them

- Patients with special needs and children always had someone with them during their examinations and treatments. Dentists and nurses spoke directly to the patients but also included their carer in explanations and discussions about treatment options. With consent, we observed clinics taking place and observed positive interactions with patients and carers, which resulted in positive outcomes for patients with complex needs. We spoke with the mother of a child with complex needs who said all of the staff were lovely and discussed all elements of care with her, saying they were like good friends.
- Patients and carers attending for pre-surgical assessment were provided with information about their care plan from admission through to discharge following general anaesthetic. This included pre-treatment instructions, key contacts information and follow-up advice for when the patient left the clinic.
- Patients and their families were appropriately involved in and central to making decisions about care options and the support needed.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care.
- We observed positive interactions between staff and patients during treatment sessions at Loughborough and Coleman Street clinics where staff knew the patients very well and had built up a good rapport. We saw a number of patients with a spectrum of learning disabilities who required very sympathetic and caring staff helping them to accept treatment in their best interests.
- Through our discussions with staff it was apparent they adopted a holistic approach to care concentrating fundamentally on the patient's social, physical and medical needs first, rather than seeing patients as a collection of signs and symptoms that required a mechanistic solution to their dental problems.
- Diversional therapy was available for patients including projecting pictures onto the ceiling and aromatherapy machines. Although we did not see these used dental nurses told us patients found them relaxing and calming during procedures.

Good

Are services responsive to people's needs?

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

We rated the community dental service as good for responsive because:

- We saw effective multidisciplinary team working and links between clinics which ensured patients received appropriate care at the right times and without avoidable delay.
- Patients from the local communities could access treatment provided they met acceptance criteria.
- There were systems and processes in place to identify and plan for patient safety issues, in advance . This included potential staffing and clinic capacity issues.
- The service used a nationally recognised benchmarking case mix tool, to inform local commissioners of the complexity of patients treated by the community dental services.
- At each location we visited, the trust had made adjustments to buildings to enable patients with various disabilities to access the buildings easily.
- General dental practitioners and other health professionals referred patients to the service for short-term specialised treatment as well as long term continuing care. The service and commissioners had developed a set of acceptance and discharge criteria so that only the most appropriate patients were seen by the service.
- The service had a very low level of complaints; the emphasis was on de-escalation and local resolution of problems.

Planning and delivering services which meet people's needs

- The service used a nationally recognised benchmarking case mix tool used by community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. This tool assessed a patient's ability to communicate, ability to co-operate, medical complexity, oral risk factors, access to oral care issues, and legal and ethical barriers to care. The tool helped to determine individual patient's need for an appointment slot which is longer in time or requires the presence of additional staff in order to provide the care required. This information is collated and shared with commissioners to enable service planning in each region.
- There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and clinic capacity issues. For example in Derbyshire, there were four sessions per week allocated for the service to treat patients under general anaesthesia.This service was provided by the dental service in a dedicated facility within a Derbyshire acute hospital. Leicestershire patients requiring general anaesthesia were treated at the dedicated facility within a Leicestershire acute hospital.
- The community dental service gave patients a choice as to where they could be treated in each geographical area. The aim of this approach was to keep waiting times for treatment as short as practically possible.
- Domiciliary visits were carried out by the service. However, we did not observe such a visit. The service told us domiciliary visits were carried out using the triage process. First appointments were for patient assessment only, unless emergency intervention was required. These visits enabled the dentist to identify treatment required and to develop a plan of care according to the individual patient's need. Wherever possible patients were supported to attend the dental clinic for care provision.
- A range of literature was available for patients, relatives and/or their representatives. This included information about all types of care and treatment provided at the different clinics.

Equality and diversity

- At each location we visited, the trust had made adjustments to buildings to enable patients with various disabilities to access the buildings easily. For example ramps and automatic doors.
- Some clinics had a 'wheel chair tipping device' that enabled patients to be treated in their own wheel chair without the need to transfer to the conventional dental

chair. For those clinics without this facility, a patient hoist device was available at each location. This allowed patients with a disability to be seen within a regular clinic environment.

- The training records indicated 95% of staff had received update training in equality, diversity and human rights as part of their mandatory training.
- The service had a contract with a national interpretation service, which provided face to face or telephone interpretation for non English speakers. The use of relatives for interpretation is strongly discouraged, as per best practice. However, staff reported difficulties with the interpretation services reliability. They told us the interpretors often did not turn up for pre-arranged appointmtnts. Management were aware of this and were in communication with the service.

Meeting the needs of people in vulnerable circumstances

- The service was primarily a referral based specialised service providing continuing care to a targeted group of patients with special needs due to physical, mental, social and medical impairment.
- The service recognised the needs of those referred into the service and made every effort to accommodate each individual patient's specific needs.

Access to the right care at the right time

- Careful management of the waiting list by the senior dental nurse responsible ensured that the service did not breach the 18-week rule (referral to treatment within 18 weeks). Urgent cases were prioritized to ensure that patients in pain were treated in a timely manner. Urgent cases were placed on the next day's operating list.
- Referral to treatment times generally met the national standard of 18 weeks with data indicating 97% of patients referred were seen within this timescale for the period April 2015 to March 2016.
- The service had a did not arrive (DNA) rate of 16.5% for Derbyshire and 11.5% for Leicestershire during the period April 2015 to March 2016. There is a DNA policy to assist staff in managing patients who fail to attend. These patients were sent a second appointment and contacted by telephone wherever possible. Any patient who did not arrive for a second appointment was referred back to their general dentist.General dental practitioners and other health professionals referred patients to the service for short-term specialised treatment, long term continuing care and where appropriate shared care. The service and commissioners had developed a set of acceptance and discharge criteria so only the most appropriate patients were seen by the service.
- The community dental service had implemented a clinician led system of referral for patients accessing the service. The process consisted of senior clinicians providing a triage system to assess the appropriateness of referrals and allocate them to the most appropriate clinic according to individual need. This system highlighted referrals into the service where further information was required. They could then arrange for further investigations such as dental radiographs or blood tests by the patient's GP or dentist. This ensured patients were seen in the right place at the right time. This system had reduced the number of inappropriate referrals to the service.
- On completion of treatment, dentists discharged patients back to their own referring dentist for ongoing treatment. Dentists sent a detailed discharge letter to the referring practitioner following completion of treatment.
- During our visits to each location, we observed clinics that ran to time and were not overbooked. This minimised delay for patients. Patients were kept informed of any delays by dental staff and were offered the opportunity to rebook appointments if clinics overran.
- The dental access service (DAC) enabled access to urgent dental care outside of normal dental practice hours and for those people who are not registered with a general dental practitioner. Clinics were available seven days a week 9am to 5pm and evenings 6pm to 9:30pm. Patients contacted the clinic by telephone and allocated an appointment during the day of the call. If all appointmentswere allocated, they could call again at 5pm to access an appointment in the evening. Demand often exceeded capacity with daytime appointments frequently filled by 10am. There was no other emergency dental service provision available, pain relief advice was provided and information on how to register with a dentist.

Learning from complaints and concerns

Good

Are services responsive to people's needs?

- Written information in the form of posters were displayed in every clinic informing people how to raise concerns and complaints. This information was available in large print.
- At each dental staff meeting, complaints, both formal and informal, were discussed by staff to allow learning and reflection to take place. We saw staff meeting minutes, which confirmed this had taken place.
- The service had few complaints; the emphasis was on de-escalation and local resolution of problems. There were ten complaints recorded as community dentistry for the period January 2015 to January2016. The majority of complaints were in relation to patients difficulties in accessing an NHS dentist. Staff were able to provide advice on this subject. There had been one complaint partially upheld by the ombudsman relating to innapropriate dental treatment provided to a patient.

Good

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.

We rated the community dental service as good for well-led because:

- The clinical directors maintained overall responsibility and accountability for the running of the service. The clinical directors had fostered a culture of accountability by devolving responsibility to other appropriate individuals within the service.
- Staff members we spoke to told us the service was a good place to work and that they would recommend it to family members or friends.
- The dental service was well led locally and with organisational, governance and risk management structures in place.
- The staff we spoke with said they felt supported by the clinical directors and that they could raise any concerns with their line managers.
- The local management team was visible and the culture was seen as open and transparent.
- Staff were aware of the organisation's vision and way forward that included the DCHS way Quality Service, Quality People, Quality Business.
- The culture of the service was one of continuous learning and improvement. At each clinic we visited, we saw staff worked well together and there was respect between all members of the dental team.
- Peer review provided an important vehicle for staff engagement
- The clinical directors were able to influence local decision making for local primary care dental services through the Local Dental Network.

However

- Clinic staff in the Leicester clinics expressed a concern about limited communication between themselves and the Derbyshire teams.

Service vision and strategy

- The service vision and strategy was an evolving one, this was because the service was being put up for tender in the coming months, which had brought a period of uncertainty to the service.
- We spoke with dentists and dental nurses who said the service had forward thinking and proactive clinical directors who were well supported by senior managers within the tust.
- The dental service was integrated with the overall trust level strategy with staff being aware of the trust overaching value the 'DCHS way' (Derbyshire community health service way).
- The clinical director for the Derbyshire sector explained the service was able to influence local decision making for local primary care dental services through a Local Dental Network. This is the government's new approach for helping to drive service improvements and reduce health inequalities for their local communities with respect to dentistry through managed clinical networks (MCN). Dentists within both the Derbyshire and Leicestershire sectors had representation on the MCNfor Special Care Dentistry.

Governance, risk management and quality measurement

- There was a risk register for community dental services. Key risks included Information technology (IT) failure due to server capacity during roll out of system across the dental service. Capacity for general anaesthetic lists resulting in increased waiting times for patients, Sunday lists - subject to funding. Organisational risk of service loss following tender process. All risks were subject to continual monitoring and were reported to the trust board.
- There was an effective governance framework with regular meetings attended by staff of all grades and professions. There was six monthly staff meetings for the whole of the derby community dental service teams, two monthly local clinic meetings and three monthly specialist meetings for example to discuss intravenous sedation. We saw minutes of these meetings which included discussions about governance issues and sharing and learning from complaints and incidents
- The dental service governance procedures met relevant United Kingdom and European legislation. Policies and

Good

Are services well-led?

procedures were available to all staff in a document folder found on the trust's intranet. Staff we spoke with were aware of this document folder and were able to show us how they accessed information.

- All locations had in place protocols and procedures dealing with the main areas of clinical practice relevant to the delivery of dental care.
- We found systems for monitoring the quality of care were always complete and up to date. This included the recommended maintenance schedules, checks of dental equipment, medicines and materials used for the provision of dental care.
- Staff records were maintained centrally;for example checks of driving licence and insurance for those travelling in their own car for business purposes and availability of dentists for out of hours work.
- We saw evidence, in staff meeting minutes, documentation audits and related actions for improvement. Actions included increased vigilance of individual patient risks and repeat audit.

Leadership of this service

- The clinical directors maintained overall responsibility and accountability for the running of the service. These clinical directors had fostered a culture of devolving responsibility to other appropriate individuals within the service in areas such as conscious sedation and general anaesthesia. This in turn had promoted a culture of individual responsibility and accountability throughout the service.
- The dental management team were responsible for passing information upwards to the trust managers and downwards to the clinicians and dental nurses on the front line. The structure in place appeared to be effective which was confirmed when we spoke to various members of staff and reviewed examples of staff meeting minutes.
- The dental management team were responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting.
- Staff confirmed that they felt valued in their roles within the service and the local management team were approachable, supportive and visible at all times.
- We found the relationship between the staff and the local management team was strong, and staff members at all levels reported there was an open door policy. Staff told us if they had concerns regarding the service they would feel comfortable speaking directly to their line manager.

Culture within this service

- There was a culture of openness between management and dental service staff with people telling us they felt able to speak out if they had concerns or suggestions.
- The culture of the service was one of continuous learning and improvement. We saw staff worked well together and there was mutual respect between all members of the dental team.
- There was an open culture between management and staff of all grades. This was apparent with regard to the uncertainties surrounding the service tendering process. The general manager had produced a film which staff were able to access through the trust's YouTube site. The aim of the film was to inform everyone about the tendering process and the bid which had been submitted.
- The morale of the staff appeared good at each clinic with staff adopting a positive can do philosophy about their practice and the challenges they faced.
- Staff were proud to work in the service and were committed to providing the best care possible for every patient. This was evident when we observed clinics at Loughborough, Leicester and Derbyshire. During clinics, we saw the dentist and dental nurse provide individualised care to a number of patients with various levels of physical and learning disabilities, some with very complex needs.
- Staff roles and responsibilities were clearly defined, with a sufficient skill mix across all grades. Staff told us of their commitment to ensuring patients received excellent care was supported by the service and its managers.

Public engagement

- It was apparent through discussions with staff that community dental services worked very much with the individual because of their often very complex needs. This also involved relatives and carers in helping the person to participate in decisions about treatment and care. Patients had severe communication difficulties and mental health issues which meant conventional public engagement tools were unsuitable for these groups of patients.

Good

Are services well-led?

- Feedback forms and Family and Friends test (F&FT) forms were available in all areas. These were in written and pictorial form to encourage all ages and abilities to participate. Dental staff had worked with the patient experience team to develop a 'Fluffy Bear' version of the family and friends card. This enabled patients to comment in pictorial format. We read twelve feedback and F&FT forms and found comments to be consistently positive about the service with all saying the service was good or excellent and some specifically mentioning how staff had made adaptions to enable their loved ones to receive treatment.
- The results of service user feedback was displayed in patient waiting areas and staff rooms.Feedback was consistently positive.

Staff engagement

- The results of the Pulse independent staff survey showed high satisfaction with the trust, with 69-70% of staff recommending it as a place to work and 89-91% of staff recommending it to their family and friends as a place to receive care and treatment.
- An independent staff survey August 2015indicated concerns about the level of staff engagement. The trust was investigating ways in which they could improve this.
- Peer review provided an important vehicle for staff engagement. During these meetings, clinicians were able to discuss current issues in relation to clinical dentistry as well as bringing clinical cases of interest to the group for wider discussion about different approaches to treatment. For example, we saw details of clinical peer review meetings for antibiotic stewardship at Nelson Street Leicester.
- Six monthly all dental staff days provided an opportunity for the whole community dental service to meet. A wide range of topics was covered, including safety and governance.
- Several staff based in the Leicestershire clinics expressed a concern about lack of inclusion and communication within the Derbyshire Community Health Service. The Leicester based teams found it difficult to attend staff meetings due to the distances involved.They had a perception of being on the outside of the team.

Innovation, improvement and sustainability

- Management in the dental community service was supportive of their staff promoting and encouraging further training and extended role oportunities.
- The dental service supported trainee dentists and dental nurses, ensuring they had opportunities to develop the skills required to make effective clinical decisions and gain experience of treating patients living with special needs.
- All staff had opportunities to undertake further qualifications or further study to enhance the patient experience. This was assessed and documented in personal development plans.
- A senior nurse based at Swadlingcote explained how dental nurses had undergone additional training and had at least two post graduate qualifications in subjects such as dental radiography, general anaesthesia and conscious sedation, and oral health promotion that enabled the service to provide enhanced care for patients.
- Senior clinicians and nurses contributed to the undergraduate and postgraduate teaching programme for dentists, dental hygiene therapy and dental nursing by providing outreach teaching services to a nearby dental school. The staff were very proud and committed to this element of their service.