Hertfordshire Community NHS Trust

Dental Clinic Health Centre, Nevells road. Letchworth. Herts. SG6 4TSRY4

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)
RY448	Howard Court	Harmony Dental Unit, Level 2, Moynihan Block. St Albans City hospital.	AL3 5PN
RY448	Howard Court	Dental Department. Peace Children's Centre, Peace Prospect, Watford	WD17 3EW
RY448	Howard Court	Dental Clinic, Health centre, High Street, Hoddesdon.	EN11 8BQ
RY448	Howard Court	Dental Clinic Health Centre, Nevells road. Letchworth. Herts.	SG6 4TS

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

Patients and their representatives spoke highly of the care provided. They confirmed they had been given privacy and were treated with dignity and respect whilst receiving treatment.

One person who had been receiving treatment for over four years told us that staff were "Patient and very good with patients". In all the interactions we saw between staff, patients and their relatives, we observed that staff were friendly, kind and took as much time as was needed. They explained what they were doing, checking they had consent throughout the treatment. Patients were listened to and staff adapted their communication appropriately dependent on the patients age and health need.

The community dental service was responsive to people's needs. The maintenance of clear, concise and detailed clinical records confirmed that care and treatment was provided in a way that met the diverse needs of their patients. However, there was no commissioned out of hours services for patients who needed to be seen urgently. It was unclear how verbal complaints were recorded and processed.

The community dental service was well-led. Initiatives had been established to improve services, and there were quality assurance processes in place. Staff spoken with confirmed that they felt valued and supported in their roles and that managers, both within the dental service and the Trust, were approachable and visible.

Summary of findings

Background to the service

Background to the service

The Hertfordshire Special Care Dentistry service is a county wide service with four clinical locations across Hertfordshire. Watford, St Albans, Hoddesdon and Letchworth and an administrative base at The Red House, Harpenden Memorial Hospital.

The Special Care Dental Service is the main referral centre for all adults and children in Hertfordshire with special care requirements. This service provides NHS dental services for patients of all ages who are unable to obtain their care from General Dental Practitioners. These included patients with complex medical conditions who cannot be managed in general practice; patients with moderate or severe learning difficulties, patients with mental health problems or children who have been referred by a General Dental Practitioner following unsuccessful attempts at treatment. The service also provided care for patients who may require the use of special equipment to enable them to receive their treatment, for example hoists, or wheelchair recliner.

The service is able to offer treatment with inhalation sedation and intravenous sedation. General anaesthesia is also provided in a hospital setting, where appropriate. The service also provides treatment on a domiciliary (in a person's own home) basis and provides dental care for a local prison.

During our inspection we visited the centres in St Albans, Hoddesdon and Watford. We spoke with patients who used the service and carers who were supporting people during their visit who did not have good verbal communication or speak English. We spoke with members of staff including dentists and dental nurses.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Head of Hospital Inspections, Care Quality Commission.

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community matron, a GP, a community physiotherapist, a community children's nurse, palliative care nurses, a specialist safeguarding nurse, specialist sexual health nurse, a dental nurse, a governance lead, registered nurses, and an expert by experience who had used community services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme. An early inspection was requested by the provider to support the trust's submission as an aspiring foundation trust.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Summary of findings

Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 16th February and 20th February 2015. We visited eight locations. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During our inspection we visited the centres in Watford, St Albans and Hoddesdon and spoke with six patients and the people supporting them. We were unable to speak with many patients directly because of their medical condition or health need but those that could speak with us told us they had a good service and were helped to understand what treatment they needed and how it would be given.

People and their carers told us they were happy they had a service that offered care to those who could not access dental services easily due to their specific health, communication, or disability needs. They told us they were never rushed and usually saw the same dentist who got to know what they liked or disliked.

The service's strategy was to work with partners to improve health, reduce inequality and improve experience of healthcare services. This is to enable everyone who required specialist dental treatment to have as easy access as possible, thereby meeting the needs of the local community. However people told us access was not easy if help was needed out of normal working hours.

Good practice

The frequencies of audits undertaken but the dental service were over and above that required by health and safety legislation. Staff told us this was so they could be sure they picked up any areas of concern quickly and because they wanted to ensure they were not only complying with the legislation but following all the Best practice guidance to provide the best possible service.

The "Purple star" strategy.

Whilst this is a local initiative within Herefordshire the skills and knowledge staff acquire are put into practice across all groups of patients who attend the specialist dental service.

Staff using age appropriate communication techniques, using simple language to describe what was going to happen. Staff us words like "sun" to describe the light, "sunglasses" to describe the protective glasses worn by patients. All patients were encouraged to touch equipment to see what it felt like. In several observations we saw staff showing people the mask they would use for inhalation gas on the next visit. They were encouraged to place on the face and shown how it fitted and in one case allowed to take it home to play with. These meant patients knew what to expect when they next visited and would be less anxious about the treatment they would have and staff adapted their communication according to people's needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take

Summary of findings

- Ensure the safeguarding policy is clear and all staff, including the safeguarding leads are certain of actions to be taken if they have concerns with regards to safeguarding.
- Ensure that all safeguarding concerns are reported via the trusts incident reporting system
- Ensure that all complaints, even those that are made verbally are recorded along with actions to remedy them

Action the provider SHOULD take

- Consider how to manage the expectations of the patient population with regards to out of hours urgent requests for treatment

Hertfordshire Community NHS Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff were aware of what may constitute a safeguarding concern. However, although there was a trust policy in place and trust records demonstrated that staff had received training, there was lack of awareness surrounding safeguarding, escalation of concerns and individual's responsibilities, therefore the trust policy was not consistently followed and as such and patients were not always protected from potential harm.

The health and safety of patients was a priority for the community dental service. There were systems and processes in place to identify and control risks to patients.

We saw evidence that incidents were reported and that the service had learned from incidents. although no serious untoward events had taken place, we saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place

Each centre was clean and well maintained. The processes for decontamination and sterilisation of dental instruments complied with Department of Health (DH) guidance. There was evidence that the service focussed on he needs of patients. There were systems in place to audit both clinical practice and the overall service.

During the provision of treatment and the decontamination of instruments staff were observed to use and wear the appropriate personal protective equipment such as aprons gloves and goggles

Patients' records were mostly in an electronic format and of a good standard with appropriate checks in place.

Emergency equipment was available in each centre, and included medication, oxygen and a defibrillator we saw that equipment checks had been carried out regularly.

We saw a comprehensive policy in use for the administration of sedation.

Detailed findings

Incident reporting, learning and improvement

The dental service used the trust wide system of reporting incidents. Between January 2014 and January 2015, 14 incidents were reported all of which resulted in no harm.

Although no serious untoward events had taken place, we saw evidence during the inspection that the service had carried out reviews of minor incidents and that sharing of these and learning had taken place. Staff members said that in once every six months they held dental locality meetings where they discussed, for example; medical

emergencies and practice issues using scenarios to illustrate the potential situations that could arise. Staff said the learning from these examples were shared across the whole service. We saw examples from locality meeting minutes which confirmed this.

Cleanliness, infection control and hygiene

All the premises we visited were visibly very clean. All the clinics we saw had on site designated decontamination rooms. We saw that in some centres treatment rooms shared one decontamination room. This meant that contaminated instruments did need to be transported through places where the public were, for example, corridors. However, they were always covered, in line with best practice.

We spoke with staff and reviewed the arrangements for infection control and decontamination procedures. Single use equipment was used where appropriate. Staff were able to demonstrate and explain in detail the procedures for cleaning and decontaminating dental instruments and equipment. Following sterilisation, all instruments were stored in pouches and date stamped All the pouches we saw were within date.

The dental nurses were responsible for cleaning the treatment and decontamination rooms. There was a daily list in place for each, which was signed as evidence it had been cleaned and checked, for example, flushing water lines and cleaning equipment in between patients. We observed staff completing these tasks during our visit The work surfaces, chair and light were cleaned in between each patient. We observed that "bagged" instruments were only opened in front of the patient. When finished with we observed that staff immediately moved the used equipment to a prepared lidded container to be decontaminated. We saw that all instruments were bagged and dated and stored in a dry area before use. Instruments used during the treatment were put into a lidded plastic box so they could be transported to the decontamination room for cleaning.

Legionella testing was done by the trust's Estates Department. We saw certificates which demonstrated this had been done. In addition, each centre had a checklist, which was completed and signed daily to ensure taps were run and toilets were flushed regularly to ensure the legionella bacteria did not have the opportunity to thrive in standing water.

There were systems in place for the segregation and correct disposal of waste materials such as x ray solutions, amalgam and sharps. Sharps containers for the safe disposal of used needles were available in each clinical area; these were dated and were not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.

Information leaflets and notices were displayed to remind people of the importance of notifying their dentist if they were taking oral anticoagulants and the associated risks.

Safeguarding

Staff were aware of what may constitute a safeguarding concern. Safeguarding featured as a topic for discussion in staff meetings. We saw a record of training for the whole dentistry service which demonstrated that all the staff had completed training in line with trust policy, with regards to safeguarding vulnerable adults and children.

Staff we spoke with during our inspection told us that any safeguarding concerns should be reported to their local safeguarding lead who would escalate the concern to the local authority. We saw that with regards to children, safeguarding concerns were raised appropriately to the local authority by the safeguarding leads. For example, a safeguarding alert to the local authority had been raised, when it was found that parents were not following an agreed be treatment plan. Subsequently, the child required multiple dental extractions due to severe decay.

However, when we spoke with staff about safeguarding vulnerable adults, there was some lack of clarity and understanding. Discussion with staff highlighted that they were not aware that the local authority took the lead for safeguarding for people who lived in their own home, or in a care home. Staff told us they had raised concerns about people who had arrived for treatment from some care homes. For example, staff had noticed a person was inappropriately dressed for the weather, it was clear that appropriate dental hygiene had not been carried out as the person's gums were bleeding. Furthermore, the person was sitting in an unsuitably sized wheelchair, which meant the patient was uncomfortable. Following raising this with the safeguarding lead, in accordance with the policy, the staff were advised, incorrectly, to contact the care home manager to raise these concerns, not the local authority. In another example staff told us they would contact the care home and if they were not satisfied with their response,

would ask the home manager's consent to make a safeguarding referral. This meant that people, who may be responsible for neglectful care, were continuing to provide care for people and the relevant local authority had not been notified about the concerns. In both examples staff told us they had not completed a safeguarding concern on the trust's incident reporting system as they were unaware and had not been advised by the safeguarding lead they needed to do so. However, the trusts' policy dated July 2013 outlined the requirement for any safeguarding concerns to be recorded on the incident reporting system. This meant that safeguarding concerns had not been recorded accurately. Two staff we spoke with said they had to ask patients and their relatives if a safeguarding referral could be made for an adult or a child. They told us that consent from either a relative or parent would be required to make the safeguarding referral. This demonstrated that some staff were confused about the difference between having to get legal consent to provide treatment and the process to follow if they had concerns that someone was at risk of abuse.

All the staff we spoke with did not know they could, as individuals, report safeguarding concerns to the local authority or Care Quality Commission.

Medicines management

Emergency equipment was available in each centre, and included medications, oxygen and a defibrillator. We saw that audit checks had been carried out regularly, to check on the expiry dates of the medicines/equipment. The nurses we spoke with were able to demonstrate how the emergency equipment worked so that they were able to set it up quickly, should it be needed in an urgent or emergency situation.

There were very few medicines kept within the clinics. However, these were stored safely. We checked a random sample. Expiry dates were checked weekly. All the medicines we saw were within date. These were stored safely and reconciled correctly in accordance with legal requirements. Medical gases, for example, oxygen and nitrous oxide were stored in locked cupboards. The cylinders in use were clearly labelled. Those cylinders not in use were secured to the wall.

Records and management

Patients' records were mostly in an electronic format. Access was via a secure password. We saw ten individual records and found them to be thorough, including essential information, for example allergies, medical history and any current medication. These were checked and signed at the beginning of each course of treatment. The records contained treatment plans and evidence of discussions with the patient and or parent/carer. Paper records, containing referral letters, consent forms and x-rays were stored securely in all the locations we inspected.

Assessing and responding to patient risk

The dental service offered a domiciliary (home visiting service) for those who were not able to attend the surgeries, for example people who were housebound because they were infirm, or had profound disabilities. Each centre had a domiciliary kit, which included equipment required for check-ups and basic treatment. There was a system of checking these kits and we saw signed and dated checklists.

The service offered a full range of NHS dental services to vulnerable groups who met acceptance criteria and had been referred by a health or social care professional. These included people who required either inhaled or intravenous (IV) sedation. We saw a comprehensive policy, for the administration of both types of sedation. The policy had been reviewed regularly. Each patient attended a pre-assessment visit with one of the dentists, to consider medical history and assess any individual risks, prior to any such treatment being considered or commenced. Inhaled sedation was available and could be titrated, whereby the mix of nitrous oxide and oxygen could be altered. This meant that sedation could be altered, to ensure a safe amount of sedation was administered according to the patient's individual needs.

Intravenous (IV) sedation, which allowed sedation for nervous or more challenging patients, was primarily carried out at Hoddesdon and St Albans clinics. There was a qualified Lead Sedationist, who provided IV sedation and they were available to receive referrals from other members of staff from other clinics.

Nervous patients who were referred via their own dentist were seen and assessed, using a recognised scoring tool, according to their anxiety levels. Any patients requiring treatment under general anaesthetic were referred to the dental team at The Lister Hospital in Stevenage. A team of clinicians worked alongside dental/hospital staff to provide dental investigations and treatment under general

Good

Are services safe?

anaesthetic. All the nurses and dentists who undertook these procedures had comprehensive training to do so. This meant patients were thoroughly assessed and then treatment given according to their dental, physical and psychological needs.

Staffing levels and caseload

The special care dental service consisted of 36 staff which included 13 dentists, 19 nurses and four administration staff.

When we visited each location, they appeared to be well staffed, although senior staff explained there were some vacancies due to staff sickness and people leaving. Staff told us the workload had increased over the last year and there were "pressures" on the service. They said this was because there was an increased need for the service and current staffing levels were not sufficient to manage the increase. In fact, when we looked at trust data the service was overstaffed against budget by one 0.8WTE and had a 3% sickness rate. This was slightly below the trust average of 4%. Waiting lists had increased from 148 people at February last year (2014) to over 270 in February this year, leading to patients having to wait longer in-between appointments. All the staff we spoke with told us demand for community dental service was increasing but staffing levels were still the same as they had been. However the clinics were able to see patients who needed to be seen urgently, for example, if were in pain, often on the same day and were able to take the time they needed when treating patients. Staff confirmed they were able to meet patients' needs, but that they had to wait longer for routine appointments.

Managing anticipated risks

During the provision of treatment and the decontamination of instruments staff were observed to use and wear the appropriate personal protective equipment such as aprons gloves and goggles.

Patients were also suitably protected and provided with bibs and safety glasses to wear during treatment.

Emergency equipment was available at each site visited included oxygen, emergency medicines and defibrillators.

The service employed the service of a Radiation Protection Advisor and each site had a dedicated Radiation Protection Supervisor.

Assessing and reporting patients risks

We found that both adult and child patients who required dental procedures under general anaesthesia were appropriately assessed by the clinical team. This included where it would be difficult, or patients may be distressed about coming into a clinic. In these cases, they could be assessed in their own home environments.

Patients requiring treatment under a general anaesthetic were referred to the Lister Hospital in Stevenage. A team of clinicians worked alongside dental and hospital staff (including a consultant anaesthetist) to provide dental investigations and treatment. This ensured there was a safe clinical environment with the critical care facilities of the hospital easily available, should they be required.

Good

Are services effective?

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

Summary

We found that the dental service positively worked in partnership with other services, for example referring dentists and healthcare professionals and the local acute hospitals, to meet the needs of patients in a coordinated and timely way.

All new staff to the trust received a comprehensive induction. This meant they were given support and guidance to ensure they were able to undertake their role safely and effectively.

The service was effective at monitoring, managing and improving outcomes for patients. We saw a number of audits that had taken place and action plans were in place to ensure that patient's care and their clinical outcomes continually improved.

Detailed findings

Evidence based care and treatment

Care was given according to available evidence of best practice, for example National Institute for Clinical Excellence (NICE), British Dental Association (BDA) and General Dental Council (GDC). For example, NICE guidelines were followed for dental recall. During an oral health review, the dental team (led by the dentist) ensured that comprehensive histories were taken, examinations conducted and initial preventive advice is given. This allowed the dental team and the patient (and/or his or her parent, guardian or carer) to discuss, where appropriate the risk factors that may influence the patient's oral health, and their implications for deciding the appropriate recall interval. Recall letters were sent out by dental staff. Staff we spoke with were aware of NICE guidelines.

Pain relief

Local, inhaled or intravenous pain relief was administered according to the treatment required and the setting where the treatment took place. There were comprehensive standard operating procedures to support the use of both inhaled and IV analgesia. These followed available essential standards for practice guidelines. The GDC requires registrants to receive appropriate supervised theoretical, practical and clinical training and be assessed prior to using sedation. We saw training records for staff with regards to training and observed staff following this guidance in their discussions and interactions with patients.

To support the verbal advice the dentists gave following treatment, written advice leaflets were available at all the centres, which gave advice on pain relief for when the patient returned home.

Competent staff

All new staff underwent a comprehensive induction. This included being allocated a mentor who ensured that the new member of staff was supported during their first few weeks. One member of staff told us they had shadowed colleagues and had additional training, which included the use of sedation and procedure for using a hoist in order to move patients safely. One dentist told us, "The training is good and we have the skills to do the job".

The clinical staff were registered with the General Dental Council, (GDC.) The GDC is an organisation which regulates dental professionals in the UK. The senior oral surgeons were also registered on the GDC's specialist list. This meant that they had met certain requirements and been given the right by the GDC to use the title 'specialist'. Specialists included oral surgery and children's dentistry. Information the Commission received from other regulatory bodies did not raise any concerns regarding the safety of dentistry provision or individual dentists.

Staff throughout the service reported that they were supported and encouraged to work across the dental network to ensure both business continuity and share skills. We saw evidence that clinical staff participated in Continuing Professional Development, (CPD) in line with GDC requirements.

Trust wide figures showed that over 90% of staff had completed some of the community Key Performance indicators (KPIs) detailed in the Dental Services Learning and Development Plan. For example: 97% of staff had completed infection control and 100% had completed Level 1 Safeguarding training. Some staff described study

days and courses that the trust had sponsored them to complete. Staff told us they were satisfied with internal and external training opportunities and they had the opportunity to have regular one to one meetings with their manager. The staff we spoke with said they had regular appraisals in order that they had the opportunity to discuss their performance and career aspirations with their manager. The trust Integrated Board Performance report September 2014 stated that for the current period the whole trust performance is 83% with the 2014/15 target of 90%.

Use of equipment and facilities

All the centres had modern treatment rooms with integrated x-ray facilities. This meant that patients could stay in the dentist's chair to have any x-rays taken. Every clinic had a large floor space to allow easy access for wheel chairs without having to move any other equipment.

Each clinic was equipped with specialist transfer/moving and handling equipment. Some clinics had a hoist and slings available and staff were given the relevant training required to operate the specialist equipment.

Each centre had an orthopantogram (OPG) a machine which takes panoramic x-rays of the mouth. We saw records relating to the maintenance of equipment. Much of the routine maintenance was carried out by the trust estates department. Specialist equipment was maintained by the manufacturer. This meant equipment was checked regularly and safe to use.

Most centres had adequate waiting facilities with wheelchair access and easily accessible toilets. The centre in St Albans had a waiting area which was accessible via a lift, however there was only one toilet that was also used by staff and patients and it was not wheelchair accessible. This meant people would need to go into another department to use the toilet. Staff told us the trust were aware and a new toilet that would be accessible for patients had been approved and they had been given May 2015 as the date building work would start.

Multi-disciplinary working and coordination of care pathways

Staff worked in partnership with other primary and specialised dental services to ensure a responsive and patient focussed service. For example, we saw evidence of referrals to other professionals such as facial/maxillary and oral surgeons. Staff we spoke with were able to explain the procedures for screening and making referrals to other specialists outside of the community dental service and showed us examples of referrals made by staff.

Consent

The trust had a consent policy that had been revised and updated in 2014. All staff we spoke with were clear on the process they needed to follow to gain consent from people. The trust learning and development plan identified that 100% of staff had completed Mental Capacity Act training and this was confirmed by all the staff we spoke with.

Patients confirmed they had given consent to treatment. They confirmed that the treatment options and plan had been discussed with them prior to giving consent for treatment to commence.

Staff were clear about the consent process when dealing with children. They explained how discussions took place, with the child, if they were old enough to understand, and with their parent. We observed staff discussing with children and their carers what they were going to do and gaining consent to proceed with the treatment in line with Fraser Guidelines.

Outstanding ☆

Are services caring?

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

Summary

Patients and their relatives told us that they were involved in their care where appropriate.

Staff told us about the different ways they responded to and cared for the diverse and complex needs of patients using the community dental service. For example, appointment times were longer than at a traditional dental surgery, to allow people with particular needs adequate time without feeling rushed.

Staff told us they used different methods to help people feel comfortable coming to the clinic. For example, for people with autism staff took pictures of the clinic, waiting area and treatment room so it could be posted to people's relatives or carers so they could become familiar with the clinic. This helped people to be less anxious and stay calm to allow treatment to take place. Friends and family test for September to December 2014 stated that 79% of people who responded were likely to recommend the service to friends and family.

We saw the service had detailed referral forms which could be completed by the parent/carer. It included information on the patients detailed medical history, risks and triggers, individual likes and dislikes, for example, whether they liked being touched or did not like crowded rooms.

We observed staff during consultations, using this information to help them ensure a successful outcome for both children and adults.

The service offered excellent customer care and recognised individuals who may need their surroundings or the way that they were treated adjusted to suit their needs. We found staff worked in partnership with others to support the individuals who used the service, producing accessible information, signage and displays and ensuring the environment was accessible.

The trust had developed the Purple Star strategy which promoted equitable health care for people with learning disabilities. Its purpose was to support best practice by ensuring services were person centred. The purple star represents staff who are Time, Environment, Attitude, Communication, Help (T.E.A.C.H) competency trained. They are evaluated to ensure they deliver a defined quality service and that it is equitable and reasonably adjusted to suit the patient group it serves. Staff received regular monitoring to ensure standards are followed.

Dignity, respect and compassionate care

All the patients we spoke with during our inspection made positive comments about the service and we saw that staff were friendly and respectful. Staff described how they ensure they have appropriate staffing levels for the needs of their patients, to allow enough time when patients are attending appointments. Staff told us they were able to give patients as much time as they needed and this meant that sometimes appointments ran a bit late, but most people were understanding.

During our inspection we heard and observed good communication between staff and patients. For example staff clearly explained to one patient about the appointment system and time frame for follow up appointments. The patient's relative did not speak English as a first language and the interpretation was given by the child, the patient. Staff explained they would ensure that an interpreter was present at the next appointment to make sure the parent understood the proposed treatment plan before starting any treatment. Staff also gave us examples where they had been concerned for a patient's welfare and called the patient's relative. This showed that the staff were concerned for people's overall well-being.

Staff told us that they had completed equality and diversity training and confirmed their awareness of the value base of the trust and the unique needs of the patients they cared for. We observed that patients were treated with respect and dignity during their time at the surgery. During treatment we observed patients being supported to feel comfortable and ask questions. They were shown equipment that would be used and able to touch it prior to treatment to see how it felt. One patient's relative told us, "Staff involved my relative in their care, listened to their preferences and treated them with respect."

The trust "Purple Star" strategy was developed to help people with learning disabilities get better health and community care. All staff complete TEACH competency standards to be open for patients with particular needs. For

Are services caring?

example patients might need a longer appointment time or need an appointment when the waiting room is quiet. The dentist may be required to visit people at home or, in the hospital, operating theatre nurses may meet patients without their gowns and masks on. Patients are treated with dignity and respect and as an individual. Staff used easy words, picture signs and symbols to make sure patients understood what was being said and to help patients get help from others like carers, community learning disability nurse or social workers. Staff told us they encourage anyone involved in a patients care to come with them to their appointments.

Patient understanding and involvement

Patients and their relatives told us that they were involved in their care where appropriate. The use of individualised patient treatment plans enabled patients and their relative to understand and participate in their treatment wherever possible.

Guidance was available for staff in relation to consent. We reviewed the consent policy dated January 2014 and the Mental Capacity Act (MCA) policy for the service. The dental service provided care, treatment and support to a large number of vulnerable patients who lacked capacity to make decisions about their treatment. The trust's consent policy provided clarity for practitioners working within the service. Clinical records we saw provided evidence that the mental capacity of patients had been taken into consideration when both assessing new patients and obtaining consent or agreement for treatment. Staff confirmed their awareness of the need to obtain consent wherever possible. They were clear as to what action should be taken when an adult patient did not have the capacity to give or withhold consent, in order to justify best interest decision making processes. We reviewed patients' notes and saw evidence of discussions that had taken place regarding treatment plans.

Emotional support

Staff we spoke with told us they enjoyed getting to know their regular patients and treat everyone according to their individual needs. We saw that one patient wanted to hold the dental nurse's hand whilst they were having a check-up, staff supported the patient and let them do that as it made them feel less nervous and more confident. This meant that patients were treated with dignity and received treatment at an appropriate pace geared to their personal, emotional and oral health needs. One patient's relative told us their relative had been coming to the dentist for some years and all staff were, "Very patient and they go at her pace".

Because of the nature of the service, some patients only attended once. Staff told us they liked trying to put new people at their ease, some of whom had not been to the dentist for years.

Staff we spoke with told us they see patients that normal dental practices cannot deal with, for example, people with autism, because they do not have the time or expertise available. Patients were often very anxious and nervous and often only came to the dentist because they were in pain. Staff told us they try and help them to be less nervous and reduces anxieties by taking as much time as was needed to settle them. This may mean that it takes a number of visits before they are confident enough to allow treatment to start.

Promotion of self-care

We observed in practice how the dentist gave oral hygiene advice to patients at each visit. The dental service provided an oral health service both in the clinics and in the community. For example, they went into schools and care homes and ran sessions to carers on maintaining good oral health to people with special needs. Staff also gave patients a leaflet which explained how to take care of their teeth in easy to read language with pictures. This meant that patients and professionals/carers were given specific advice according to patient's particular needs.

Good

Are services responsive to people's needs?

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

Summary

We found that patients could not access treatment and urgent and emergency care when required as there was no commissioned out of hours service and no hospital out of hours specialist dental provision. This meant them having to wait for a period of time in pain before they could access appropriate treatment. This meant people were diverted to the NHS 111 service or pay privately for that service if they felt they could not wait.

It was unclear how verbal complaints were recorded or processed as staff told us they did not record these.

All the staff we spoke with were passionate about providing good quality care in response to people's individual needs.

Staff told us they had longer appointment times as many of the patients had extra needs they need to consider. For example; difficulty in communicating and understanding that required time for staff to check that patients understood their treatment as far as they could. In addition, patients may have had physical disabilities that mean they need particular positioning to enable treatment to take place.

The friendly, person centred dental care provided was well suited to those patients who were nervous or anxious about dental treatment.

A domiciliary (home visiting) service was available if needed during normal working hours. Staff worked collaboratively and in partnership with everyone involved with the patients care to deliver better oral health in accordance with evidence based practice.

The service offered emergency appointments enabling effective and efficient treatment of patients with dental pain during normal daytime opening hours where patients could be seen and helped as soon as possible in an emergency.

The service worked collaboratively with local hospitals to ensure patients did not have to wait to long for treatment that required a general anaesthetic.

Performance information showed that patients were seen within a variable time frame with some being seen within a few weeks and other's waiting 21 weeks. National Health Service (NHS) guidelines say that people should wait no longer than 18 weeks.

Detailed findings

Planning and delivering services which meet people's needs

Staff reported that many patients were referred to the community dental service for short-term specialised treatment. On completion of treatment, patients were discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist.

Performance information showed that patients were seen within a variable time frame with some being seen within a few weeks and other's waiting 21 weeks. National Health Service (NHS) guidelines say that people should wait no longer than 18 weeks. Staff told us that demand was high and this meant people had to wait longer for an appointment. People were sent a letter advising them to contact the service should their need become more urgent whilst on the waiting list.

Referral systems were in place, should the community dental service decide to refer a patient onto other external services such as orthodontic or maxillofacial specialists.

Staff told us patients who were in pain were prioritised for treatment and could be seen the same day on some occasions. Staff showed us referrals where people had been referred for pain and had been fast-tracked for treatment. These referrals included extractions under general anaesthetic.

Where people found it traumatic or they were unable to attend a clinic, for example if they had a profound disability or were frail, then a domiciliary service was provided in their own home. Staff highlighted that good communication between the dental services and people's own GPs helped them to meet people's needs.

Where people had additional needs, such as a learning disability, staff encouraged parent, care worker and social care professionals to be involved. The clinic booked

appointments around individual people's needs. Staff told us they would ask everyone involved in people's care what time was most suitable and tried to accommodate requests when booking appointments.

The service worked collaboratively with local hospitals to secure operating time for patients who required dental care in a hospital setting, for example, procedures under general anaesthetic. Because the dentists and surgeons worked collaboratively and the operating lists were regular, staff told us patients did not have to wait very long for treatment. We were unable to find information on exactly how long individual people waited as this information was not made available to us.

We saw that the centres had specialist equipment to enable people who for example were wheelchair users or who were obese, to receive dental treatment. Appointments were timed to last longer than is usual at dental surgeries to allow people with more complex needs the time they needed.

Equality and diversity

We found that people had individual holistic assessments which covered a number of areas including communication needs, physical needs such as specialist equipment they might need and any travel difficulty or caring responsibilities they might have. This enabled them to support people by, for example, arranging an interpreter, specialist equipment or appointment times to suit people's needs wherever possible. In another example staff told us some people needed to follow a specific routine due to their autism. Staff said they followed the same routine every visit including ensuring using the same waiting room, clinic room, and staff people knew. Staff said they had taken advice and information from all those involved in providing their care and support before starting treatment. They had a written copy of the behaviour care plan in the individual's assessment.

We observed three clinic visits where discussion took place on people's individual needs and what would need to be in place to enable successful treatment to take place. For example, one person needed to get used to the building and equipment before treatment could take place. Staff arranged for them to become familiar with equipment by touching and handling it. Staff showed them the mask they would use and allowed them to play with it and try it on whilst at the time explaining how it would be used. They then took it home to get familiar with it before any treatment would start.

The trust provided an interpreter service if needed. Staff told us it was very easy to access. We observed staff contacting this service on the phone and using during treatment to explain what was happening to the patient.

Meeting the needs of people in vulnerable circumstances

We saw evidence of integrated working between the community dental team and other organisations. For example other health care services, including local dental surgeries, social workers, and care homes. The service worked with a range of groups including young children; teenagers; adults; vulnerable people and other health professionals to deliver better oral health in accordance with evidence based practice.

We noticed there was no information on for patients regarding difficulties parking at some of the units. People's relatives and carers told us St Albans hospital had very limited parking and it was very expensive.

Access to the right care at the right time

Some services were not provided at all four units. For example sedation, was not offered in all the centres. Some treatments, such as extractions, were not available in every centre, every day. This meant that for some treatments, patients had some distance to travel. However, this ensured the right facilities were available to them for specialist treatments.

A Hertfordshire Special Care Dental Service leaflet informed people about the service and what to expect when they visit. The leaflet included information on the interpreter service and transport arrangements.

We saw that information on the opening hours of the units were not written on the patient leaflets. There was no information on at what times or days the service was available at the four units. Information was available on how to contact the out of hour's service. One patient told us that they had rung the emergency out of hours number to get help for their child who had particular special needs and was in pain. This number was the NHS 111 service. They said they had been given the wrong information by the helpline. Staff there had advised them go to the local

hospital. However, emergency dental treatment was not available at the hospital and they were told they would need to see a dentist privately. They were given a list of dentists to contact, but then realised they were private dentists charging up to £100 for a consultation. Further treatment would incur more costs. They told us they had not been able to get any help from the NHS dental service until the next day and then waited three days for an appointment, even though it was urgent.

Staff we spoke with confirmed that was no out of hours service provided as this service was not commissioned by the local Care Commissioning Group (CCG). This meant that people were not able to access dental community services out of hours. Private services only were available.

Staff told us that if a patient had suffered trauma, had a facial swelling or was bleeding they would be given an appointment on the same day, as they would be fitted in during or at the end of surgery. This meant that urgent clinical needs were assessed and acted upon during normal working hours.

Staff told us that the wait for non-emergency appointments used to be around a week, but due to demand it could be three or four weeks before a first appointment.

Complaints handling and learning from feedback

A leaflet entitled 'PALS and Complaints' was available in reception areas. Posters were displayed in waiting areas regarding making a complaint. We found the service maintained records of any written formal complaints received within each sector, together with details of the outcomes and any action taken to improve the service. This provided evidence that written complaints were listened to and acted on.

Staff told us they would try to resolve any practice complaint immediately. If this was not possible, the complainant was referred to the service manager who followed the trust's complaints policy. However, we found that there was no threshold or guidelines regarding what constituted a recordable complaint. This meant that all complaints, particularly verbal, were not recorded and opportunities to improve the service lost.

Some patients and carers we spoke with were unsure whether a verbal complaint would be recorded and considered in the same way that a written one would be. One told us they had complained verbally and did not think anything was going to be done about it. They said they had complained on the telephone about the time it took to get an urgent appointment, but no one had said they would pass on their complaint and they felt no one was listening to them. No one had contacted them to follow up their complaint. They were not aware they could contact the "Patient Advice and Liaison Service" (PALS) to make a complaint until we showed them the leaflet in the unit.

We saw a number of posters inviting patients to provide feedback on the service they had received and saw an easy read leaflet with symbols for people if they could not read fluently. In St Albans, leaflets were not easily visible as they were on top of high units in a corridor. However each clinic we visited had a post box where comments could be left. Postcards were available for people to write their comments on. In one unit staff told us most of the comments were negative comments about the toilet facilities. Staff told us these were being acted on in order to improve the service. Some staff were unclear as to whether or how a verbal comment/complaint would be recorded and processed. However, minutes of staff meetings we saw, highlighted that patient experience was a topic for discussion and confirmed the organisation was monitoring feedback that it had received on an ongoing basis**.** Staff told us they had very few complaints and most were about the environment.

Access to care as close to home as possible

Specialist services were only accessible at four centres across Hertfordshire, which meant that people may have had to travel some distance to get to a centre. However, we did hear staff inform patients that appointments could be made at centres closer to their home if the treatment they needed was available. They said that people were offered appointments on a priority basis and that might mean they have to travel across the county to get the right treatment. On the day of our visit one child had travelled with their relative for over an hour by train, to get to the clinic, as they could not drive. Staff discussed the next appointment with the relative and arranged a more convenient day and time which meant a family member could drive them to a clinic that was nearer to them.

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 found that that the leadership, management and governance of the community dental service assured the delivery of high quality, person centred care.

The culture was built around providing a service to people who were vulnerable and at risk. There was an ethos of always doing the right thing for this patient group. The community dental services management supported this culture and helped staff develop to reach the standards required to ensure this group of patients had a service that reflected their needs.

There was a clear leadership and management structure; each clinical lead had defined areas of responsibility. There was a commitment from the managers to learn from feedback, complaints and incidents. However, some staff told us they did not record verbal complaints and tried to sort them out locally at the time if they could, so some opportunities to gain feedback from patients were not used. Most of the staff we spoke with however could demonstrate how practice had been improved through learning from those incidents that had been shared.

Staff we spoke with told us that the managers were very approachable and the culture within the service was seen as open and transparent.

Staff were aware of the practice ethos to provide a caring and responsive service. They said that it was a good place to work and they felt well supported.

There were structures in place to manage risk. We saw evidence of service improvement initiatives and some monitoring of the quality of the service.

The service had instigated a number of good practice strategies including the “Purple Star Strategy”. To be awarded a Purple Star people working in the service had to be taught about learning disabilities and agree to the Purple Star promise. Its purpose was to raise awareness and influence changes in practice.

We found that health and safety procedures followed best practice guidance. Equipment used in support of patients care and treatment was installed, checked and maintained in line with the manufacturer’s instructions, current best practice guidelines and legislation. The dental service carried out any necessary x-rays safely and in line with current best practice guidelines and legislation.

Detailed findings

Service vision and strategy

Staff informed us that the value base of the trust was openly discussed as part of the performance and development review system. Staff also confirmed that they understood the vision of the trust and were aware that information on strategic plans for the organisation could be accessed via the trust’s intranet or discussed at staff meetings.

Governance, risk management and quality measurement

All the staff we spoke with were passionate about working within the service and providing good quality care for patients.

We saw evidence of service improvement initiatives and regular monitoring of the quality of these services. For example, infection control audits took place every three months as did x-ray audits. Radiography quality audits from 2014 showed that over 1000 radiographs were audited. The purpose being for dentists to peer review their own X-rays. In addition, there were discussions with other professionals using case studies. Staff told us this was to ensure they had consistency and clarity on individual treatment plans for people by sharing learning and expertise across the service.

The trust had a clinical governance system in place, which was used to escalate risks to senior management and ensure there was appropriate investigation of issues and learning was shared.

Leadership of this service

Staff spoke highly of the senior managers within both the trust and the dental service, and said they provided good direction and leadership. Staff gave examples of changes

Good

Are services well-led?

made to improve the quality of service, many told us about the Purple Star strategy, which they felt had made a very positive impact on the care that patients received. They said they felt listened to by their managers.

Staff were encouraged to complete training over and above that required by the trust. The service ensured staff were competent in all aspects of their clinical role. One member of staff told us the trust had supported them by providing study leave and partial funding to complete a national sedation dental nursing qualification and further qualifications in special care dental nursing. Staff said managers made it easy to meet the GDC continuing professional development requirements. We found dental services were above the target trust required in all mandatory training areas.

Staff told us that some members of the board had visited their areas of work to familiarise themselves with their role.

We saw that information was shared from some of the meetings, for example, policy and process changes that had been made and these were available to staff on the computer system.

Culture within this service

During our inspection, staff told us that they had opportunities to meet with team members, managers and members of the senior management team including the Chief Executive of the trust. For example, a range of meetings were co-ordinated at different intervals throughout the year to enable opportunities for staff to communicate and to share and receive information.

Staff confirmed that they felt valued in their roles and that managers within the service were supportive, approachable and visible.

The Trust had also developed a number of initiatives to share and receive information from staff. These included six monthly locality meetings and annual and quarterly staff surveys.

Innovation, improvement and sustainability

Staff told us that most of the staff had completed the TEACH workbook. This is part of the Purple Star Strategy within Hertfordshire in collaboration with the Health Liaison Team and Community Learning Disability Nurses as part of health promotional strategy. Staff told us they have to undertake competency based training and are fully involved in evaluation, monitoring and review of The Purple Strategy. The strategy will help to raise awareness of the needs of people with learning disabilities and influence change in practice to deliver real improvements to services they receive.

During our inspection we visited the centres in Watford, St Albans and Hoddesdon and spoke with six patients and the people supporting them. We were unable to speak with many patients directly because of their medical condition or health need but those that could speak with us told us they had a good service and were helped to understand what treatment they needed and how it would be given.

People and their carers told us they were happy they had a service that offered care to those who could not access dental services easily due to their specific health, communication, or disability needs. They told us they were never rushed and usually saw the same dentist who got to know what they liked or disliked.

The service's strategy was to work with partners to improve health, reduce inequality and improve experience of healthcare services. This is to enable everyone who required specialist dental treatment to have as easy access as possible, thereby meeting the needs of the local community. However people told us access was not easy if help was needed out of normal working hours.