Care Quality Commission

Harrogate and District NHS Foundation Trust

RCD

Community dental services

Quality Report

Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX
Tel: 01423 885959
Website: www.hdft.nhs.uk

Date of inspection visit: 2-5 February 2016
Date of publication: 27/07/2016

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)
RCDX1	Monkgate Health Centre, York	North Yorkshire Dental Care	YO31 7WA

This report describes our judgement of the quality of care provided within this core service by Harrogate and District 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 Harrogate and District NHS Foundation Trust and these are brought together to inform our overall judgement of Harrogate and District 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?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider say	7
Good practice	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	8

Summary of findings

Overall summary

Overall we rated community dental services at this trust as outstanding. Services were effective and focussed on the needs of the patients treated and the wider community through oral healthcare education services. We observed that the service was able to meet the needs of patients who visited the clinics for care and treatment due in part to the open minded and flexible approach the staff had towards delivering care and treatment.

There were systems for identifying, investigating and learning from incidents and the service had a strong culture of reporting incidents. The service protected patients from abuse, and where harm had been caused, thorough investigations had occurred and changes to the service implemented to prevent further harm occurring. Infection prevention and control procedures were in place and audits were carried out regularly. The environment was clean and tidy. In some clinics, site maintenance was poor, this had been identified in the risk register and staff had made changes in practice to ensure patients were not put at risk.

Patients and carers reported positive experiences of care. We observed examples of staff providing care in a compassionate and supportive way. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke passionately about their work and the treatment they provided. This was reflected in the comments from patients on Care Quality Commission share your experience cards which were all positive.

At each clinic we visited, staff responded to patient needs. Effective multidisciplinary team working ensured patients received care that was at the right time and right for their needs. Delays to treatment were kept to a minimum through effective time management and escalation strategies, however managers had identified staffing issues as being a concern.

The service was well led and both the operational and the trust wide management team were visible. Staff told us that the culture was open, transparent and that managers were approachable. Staff said they felt well supported and valued, with many having worked for the service for many years. The service had a strategy with aims and objectives for promoting dental health with patients and the wider community.

Summary of findings

Background to the service

Information about the service

Harrogate and District NHS Foundation trust provided a dental service for children and adults who required specialist care which they were unable to receive in a general dental practice.

From July 2014 to June 2015 the service had 18,043 attendances, a mean monthly rate of 1,504.

Oral healthcare and dental treatment was provided for children, and adults with physical, mental, emotional, intellectual or sensory impairment or disabilities. The service also provided domiciliary care to those who could not leave their homes.

Some clinics offered sedation by either inhaled gasses or via intravenous medicine. This was for treatment where local anaesthetic alone would not be adequate and conscious sedation was required. Conscious sedation is a method of blocking pain and helping patients to relax during dental procedures.

General anaesthetic services were available for children where extraction of a tooth under local anaesthetic would not be appropriate. This was used for the very young, extremely nervous, children with special needs, and children requiring several teeth removed. This service was also available for adults with special needs. General anaesthetic procedures were available at York and Harrogate Hospitals.

The service also offered an access clinic in York to provide treatment to people in pain or with swelling on, a walk in basis.

There were 14 community dental clinics covering most of North Yorkshire. These were divided into four geographical areas, Skipton and Settle to the west, Cattrick and Northallerton to the north, Scarborough and Whitby to the east and Selby, York and Harrogate to the south. During our inspection we visited four locations, the Kingswood Surgery in Harrogate, the Monkgate centre in York, Northway in Scarborough and Whitby community hospital.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Independent Chair

Head of Inspection: Julie Walton, Care Quality Commission

Team Leader: Karen Knapton, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a qualified dental nurse practice manager.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 2 to 5 February 2016

Services were provided across 14 community dental clinics across North Yorkshire. During our inspection we visited four sites; the Kingswood Surgery in Harrogate, the Monkgate centre in York, Northway in Scarborough and Whitby community hospital.

We spoke with four patients and their carers. We spoke with 10 members of staff, observed practice and looked at two sets of patient notes in each clinic we visited.

What people who use the provider say

We received 25 responses to CQC comment cards about this service. All commented positively on the service, specifically around the caring and professional nature of the staff, accessibility in relation to appointments and the cleanliness of clinic environments.

Good practice

Outstanding Practice

The environment was very clean, and although there were some infection prevention and control issues identified in the service risk register, staff had adapted and overcome these to offer exceptional safety.

The individual care offered to patients was specific to the patient's needs. Where conventional care would not meet the needs of the patient, the service was willing to adapt to meet their needs. This included carrying out assessments in non-clinical spaces to enable patients to relax and providing calming reassurance to distressed patients. Staff had a high level of skill in creating a relaxing and professional environment. Meeting the needs of a patient was seen as a challenge to be met and patients were not turned away for being too complex.

The service responded effectively to the needs of the community and staff were actively seeking out groups of people who were at risk from poor dental hygiene or who were normally excluded from routine dental treatment. The work the service was doing with prisoners, the homeless and people with a history of substance misuse was reflective of this inclusive approach to ensuring all people can receive the best dental support.

The service leadership was effective, thorough and well respected by the staff. Information and governance was well organised and documented appropriately. Managers understood the needs of their staff and worked hard to maintain a 'family' feel to the service that was referred to by several members of staff we spoke with. Managers were approachable and very much part of the team.

The trust leadership was well respected and staff spoke highly of the board, not just in a professional capacity but also in terms of their visibility and approachability.

Care Quality Commission

Harrogate and District 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

Summary

The safety of the community dental service was rated as good because.

- The service has a strong culture of incident reporting and investigating.
- All clinics were clean, with no incidences of Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium difficile reported over the time frame of April to September 2015. All clinics had excellent results in handwashing audits.
- The service had completed effective root cause analysis and implemented changes and training as a result of incidents.
- Staff training was up to date in all areas except safeguarding and staff were encouraged to take on extra training opportunities.
- Record keeping was consistently of a high standard, both on paper and on computers.
- Risks were safely assessed and managed. Practice was adapted as required to minimise risks.
- Staffing levels were safe for services offered, with high retention and development. However, staffing was identified in the service risk register as an area of vulnerability. Senior staff told us that staffing constraints were increasing waiting times and limiting the number of patients that could be seen.
- The service had a thorough major incident plan, which was responsive to the needs of the service.

However, we found that-

- There had been a never event and a serious untoward incident, both relating to tooth extractions.
- There were infection prevention and control issues at some sites that were not being addressed in a timely way.
- There was limited hand washing facilities at the Whitby Community Hospital.
- Not all dental and medical staff had completed relevant training in safeguarding adults and children.

Detailed findings

Safety performance, Incident reporting, learning and improvement

Good

Are services safe?

- There had been 21 incidents reported on the National Reporting and Learning System (NRLS) between December 2014 and November 2015. Of these18 were reported as no harm incidents and three low harm incidents.
- Two serious incidents were reported between April and July 2015. Both the incidents occurred in surgical environments and were related to the extraction of wrong teeth. One was reported as a serious incident, where the extracted tooth was deciduous (a baby tooth) and one as a never event where a tooth was extracted but successfully re-implanted. A never event is a serious, largely preventable patient safety incident that should not have occurred if available preventative measures had been implemented. Following investigations, changes were made to pre-surgery check lists to ensure all members of the team were clear as to what procedure was being carried out and that the consent form, treatment plan and theatre list matched up prior to treatment commencing. Staff received training where required to ensure events did not occur again.
- Safety performance was not compared with other providers by the trust, due to the specialist nature of the work carried out. There were plans to introduce a dashboard to enable comparison.
- Following all reported incidents a root cause analysis was carried out and documented. A root cause analysis is a process for understanding and solving a problem, establishing what negative events have occurred, then consider the systems around those problems, and identify key points of failure. Finally, determine solutions to address those key points the results of this were shared in local team meetings, in regional governance meetings and trust wide where appropriate.
- Where people had been affected by something going wrong they were informed, either verbally straight away or as soon as possible by letter or telephone call. The services incident log indicated that communication was maintained with patients and their families until a satisfactory conclusion had been reached and the incident was closed.
- The trust had a duty of candour policy and this was adhered to by the service. Evidence of this being used was observed in the root cause analysis of incidents.
- Staff understood their responsibilities to raise concerns and report incidents. Staff told us they would report verbally to a senior member of staff and also record incidents on an electronic incident reporting system. Staff understood that some incidents needed to be reported externally and could give examples, such as patient harm or harmful chemical spillage.
- Where care was provided in people's homes, the same incident reporting system was used. Staff would return to clinic after the domiciliary appointment and complete incident reports then.

Safeguarding

- Staff were aware of the trust's safeguarding policy and had completed training in safeguarding adults and children. Training was available as an e-learning package for Level 1 and a face to face session for Level 3 safeguarding adults and children. The target of 75-95% had been met in all areas of staffing except medical and dental staff (74% for e-learning, 58% face to face training). This was an area that management were aware of and were working to improve compliance by the end of the year.
- Staff were knowledgeable about safeguarding issues that may affect the patients they treated and were comfortable discussing concerns with patients and carers as required.
- Safeguarding was a standing item on staff meeting agendas. The service worked closely with social services, other healthcare providers and residential providers to ensure the safety and protection from abuse of all its patients.
- Dentists were aware of safeguarding concerns that could be related to dental care, for example frequent non-attendance, or high levels of dental decay as a sign of neglect. Where this happened, staff would contact other related health professionals to share knowledge of safeguarding risks.

Medicines

- We found that arrangements for managing medicines used for intravenous sedation were stored in locked cupboards. These were audited regularly by both managers and the trust pharmacist when medicines were delivered to the clinics to ensure quantities were accurate and medicines were in date.
- The service had decided not to dispense medication and dentists provided prescriptions instead. Prescription pads were kept secure to ensure against misuse.

Good

Are services safe?

- Emergency drugs were available, in date and stored correctly with the resuscitation equipment.
- Clinical waste and sharps bins were disposed of within a locked compound and were collected by an approved carrier. Records were kept to ensure these were disposed of correctly.
- Clinical specimens and extracted teeth were kept in a secure container in a locked room. Dental casts were appropriately labelled and stored safely in a secure area. Learning from incidents showed that in an incident recorded in 2014, a patient had gained access to extracted teeth; as a result these are now immediately removed from clinic spaces.

Environment and equipment

- We observed that equipment was stored safely, in sterile packaging and was well maintained. We saw evidence of equipment that had been delivered being returned where packaging was damaged or equipment was faulty.
- There were plentiful supplies of dental instruments and equipment. The service had purchased large numbers of instruments to minimise the risk of these being lost or delayed in transit to the central sterilising service in Harrogate.
- At each site we visited there was emergency resuscitation equipment in line with Resuscitation Council guidelines 2015, including a defibrillator. These items were checked daily and these checks were recorded.
- At each site visited radiation protection files were available. Each clinic room had radiation sensors as required. All X-ray equipment was appropriately maintained and serviced. Daily checks were completed and recorded. X-ray developing equipment was available in each clinic and was appropriately maintained, serviced and was checked daily ensuring patients and staff were protected from radiation exposure.
- A copy of the local rules was displayed with each X-ray machine. We saw evidence in patient records that X-rays were prescribed, justified and reported on appropriately in line with national radiological guidelines.
- The service risk register identified that in some clinics X-ray equipment was nearing the end of its 10 year lifespan and replacement equipment was required in the next 12 months. Regular checks were carried out to make sure that X-ray equipment was well maintained and serviced.
- The environment at the Whitby Community Hospital was in a poor state of repair. In the waiting area the coving was coming away from the walls and linoleum floors were lifting.
- There was limited storage available in the Whitby department and storage space available was not always suitable, for example high shelves and cupboards in patient areas.
- There was evidence of damp in the plaster of one of the treatment areas in Scarborough, and though remedial repairs had been made the problem persisted.
- We were informed that environmental maintenance was a problem in several of the older clinic areas (Whitby, Scarborough and York clinics) and that despite issues being logged on the risk register, there were currently no plans in place to resolve these issues.
- At each clinic site we visited there was equipment available to enable staff to respond to medical emergencies. This included airway management equipment, an Automated External Defibrillator (AED), oxygen and emergency drugs. Equipment was in line with the requirements of the Resuscitation Council guidelines 2015. We observed that there was no size zero oropharyngeal airways. Although this is unlikely to be used within the clinic, it is a required piece of equipment. We were assured by senior staff that this would be rectified.
- Emergency medicines were observed as being in date, in sealed packaging and appropriate for the needs of the service. A resuscitation trolley was available in every area where patients were treated, this ensured there would be no delay to treatment in an emergency.

Quality of records

- The service used an online patient record system. This was supported by a paper record for recording information specific to dental services and for attaching x-ray films which were not able to be digitised.
- Written notes, referral letters and X-rays were stored in individual patient files and kept in locked cupboards in offices that were not accessible to the general public. Ensuring that patient identifiable information was protected appropriately.

Good

Are services safe?

- We examined records at each clinic inspected (eight in total) and found them to be appropriately detailed. The individual needs of patients were recorded and included their medical history, consent to treatment, oral examination, treatment plans and costs, where appropriate. Written records reflected the information on the electronic system. They were clear, concise and legible. Patient safety and safeguarding alerts or considerations were documented including a plan of action where required. We saw that allergies and medications used (including over the counter medicines) were recorded.
- Where hard copy records needed to be passed between clinics, internal couriers were used to ensure the security of the notes.
- The service had an audit into the quality of record keeping from January 2014 to February 2015 having identified some weakness in detail and accuracy in this area in 2011. The audit looked at 40 patients at the Skipton and Harrogate clinics and outcomes were fed back in staff meetings. Senior staff told us that following this audit, standards were found to have improved and spot checks on records found the quality, detail and accuracy standards were being maintained.
- The World Health Organisation (WHO) surgical checklists were used in surgical procedures. Following a never event and a serious incident, training was implemented to ensure all staff present for a procedure agreed on the treatment plan to be carried out and that this matched the patient notes and expected treatment .

Cleanliness, infection control and hygiene

- The service used the trust's central sterilisation service for processing contaminated instruments. Dirty instruments were stored in boxes, which were removed by the central sterilisation service and replaced with clean instruments. This service was used throughout the trust and met HTM 01 05 guidelines for decontamination in primary care dental practices. Within the clinic rooms there was adequate storage and workspace for clean and dirty instruments.
- Staff described the process of removing dirty instruments to storage boxes in a dirty utility room or area, which was separate from the clean utility area to ensure there was no risk of cross contamination.
- We observed records of instruments returned to central sterilising unused, for reasons such as damaged packaging, defects or dropped on floor.
- Hand washing facilities were available in all clinical areas and alcohol gel dispensers were available throughout the clinics. Posters were displayed by sinks advising on correct handwashing technique and sinks for handwashing were labelled for this task. Staff were observed as being bare below the elbows. During clinical work, all staff wore gloves, aprons and masks. Where aerosol generating procedures were used, eye protection was available. Personal protective equipment was disposed of appropriately.
- Clinical waste and sharps were handled, stored and disposed of appropriately. The service kept a log of all waste removed by the contractor to ensure compliance with the Environmental Protection Act 1990.
- Cleaning schedules were in place and were stored in each clinical area. These were signed each day to indicate that cleaning had been carried out by the responsible dental nurse and green, 'I am clean' tags were used to indicate when items had been cleaned. Senior staff would regularly check that these were filled in appropriately and that cleaning was of an acceptable standard.
- There were clearly defined roles as to who was responsible for cleaning areas or equipment. This ensured that staff knew their responsibilities and areas were not forgotten.
- All sources of water were run daily to flush pipework to remove stagnant water and prevent against legionnaires contamination.
- Infection prevention and control audits were carried out monthly and where submitted were consistently 100%. All clinics within the trust had submitted data, but not for every month despite the expectation to submit data monthly.
- Staff identified areas at the Whitby clinic where maintaining high levels of infection prevention and control was difficult due to estates issues. Staff had adapted their practice to ensure high standards were maintained by using a plastic bowl where the sink was cracked and could not be effectively cleaned due to damaged worktop and seals.
- There had been no recorded cases of Clostridium difficile (C-difficile) or Methicillin-resistant Staphylococcus aureus (MRSA) within the service over the time period of April 2015 to September 2015.
- At Whitby Community Hospital the clean utility room was not fit for purpose as the sink was not sealed appropriately, the worktop was lifting allowing access

for water and dirt into the wood below. The tiling on the splashback was cracked and hard to clean due to damaged grout. Staff were maintaining safe practice by using plastic bowls, however this was a temporary solution.

Mandatory training

- Staff told us that there was good access to mandatory training across the service. The trust utilised both face to face training sessions and e-learning. Due to the wide geographical spread of the service and the difficulty for staff to get to Harrogate District Hospital for training, the service had arranged for training to take place in areas more convenient for staff.
- All staff except medical and dental staff were meeting targets for of 75-95. For the majority of staff groups including administration and nursing, training completion was 100%.
- Mandatory training topics included safeguarding adults and children, infection prevention and control and managing emergencies.

Assessing and responding to patient risk

- Prior to any treatment, a risk assessment was carried out as part of the treatment plan. This included assessing appropriate treatment, potential challenges and the wishes of the patient. Risks such as difficulty maintaining a patient's airway, behavioural challenges and medical complications were considered and managed appropriately. We observed evidence of this being recorded in patient records and staff told us that this was a key component of providing a safe service for their varied patient groups.
- Dental and nursing staff were trained in recognising deteriorating health and medical emergencies. Although clinical observations were not routinely monitored for general dental care, where a patient was sedated or under a general anaesthetic, trained staff would monitor patients and respond to their changing needs immediately.
- We looked at eight sets of patient treatment records across all clinics. We found that patient safety alerts were recorded, such as allergies or medical conditions. Safeguarding alerts or concerns were also recorded.
- Where staff had safeguarding concerns, these were shared with appropriate care providers such as the patients GP or social services.
- Detailed risk assessments had been carried out on all aspects of health and safety. Where risks had been identified, plans were in place to minimise their impact. For example, senior staff told us that there were weight limits on dental chairs and that increasing numbers of bariatric patients increased risk of equipment failure. The service had identified the weight limits of individual pieces of equipment (dental chairs, hoists etc.) and were able to plan appropriate clinic space for patients who required particular pieces of equipment. Plans were also in place to replace older equipment with modern equipment with higher weight limits. Where a patient's weight exceeded the limits of the equipment, arrangements would be made for treatment to be carried out in hospital, where a greater range of support equipment was available.

Staffing levels and caseload

- Staffing was identified on the service risk register as being of moderate risk that was unlikely to cause harm. Senior staff told us that the recruitment of both dentists and dental nurses was a service wide problem due to the wide geographical area covered and limited numbers of staff having the specialist skills required.
- Caseloads and clinics were planned around staffing availability and management staff told us that staffing shortfalls were limiting the amount of clinic time the service was able to provide and that this had increased waiting times across the service.
- There were vacancies in both dental and nursing staffing, for example, as at November 2015, the service had 2.8 WTE vacancies for medical/dental staff. The managers told us they had trouble covering short term vacancies, such as maternity leave. Agency staff were not used due to the specialist nature of the services used. Staff were generally flexible and would work extra shifts to cover staffing shortfalls. Following identified shortfalls in dental staffing, a new trainee had recently been taken on to reduce pressure on the dental team.
- Skill mix of staff met the needs of the service. Nurses had undertaken further training in radiography and public health promotion in order to provide a more flexible and efficient service by taking responsibility for X-rays and education. There was a paediatric specialist dentist within the team, and all had interests in specialist dental services.
- The service offered a domiciliary care service, staffed by dentists and dental nurses.

Good

Are services safe?

- Time allocations for assessment and treatment were broken down into five minute segments, and then a number of segments were booked as required to ensure sufficient time was allocated. This had been proven to be an appropriate system as clinics generally ran to time and few treatments ran over their allotted time.

Managing anticipated risks

- The service had an up to date risk register, which recorded the level of risk, the likelihood of the event happening and plans to minimise or overcome the risks. Items on the register included risks from poorly maintained estates, staffing level concerns and key dental equipment coming close to end of their warranty life span.
- The service did not experience significant seasonal fluctuations. There was greater use of the access clinic in York during the summer months due to visitors to the region.
- The impact of adverse weather was mitigated by the use of a telephone contact system, which enabled staff to be contacted easily to ensure staff were able to get to and from the clinics and if they were unable, where else they could go if required.
- All staff undertook annual training in either intermediate life support or basic life support techniques appropriate to their clinical level and role. Those staff who worked in general anaesthetic services or intravenous sedation undertook the higher level of training in line with guidance from the Royal Collage of Anaesthetists 2015. Where anaesthesia was being carried out, dental staff were supported by an anaesthetist and two dental nurses who were trained in general anaesthesia.
- Patient records we observed indicated that prior to sedation, a full medical history, height, weight and base line observations were recorded to ensure appropriate and safe treatment.
- During sedation procedures, clinical observations were recorded regularly to ensure that any deterioration could be noted quickly and managed appropriately. These observations were recorded in patient records.
- Health and safety policies and procedures were available on the trust intranet. All policies seen were in date.

Major incident awareness and training

- Although the service was unlikely to play a key role in a major incident situation, the service had plans in place to ensure that the continuity of the service could continue with minimal impact. This included plans on how to deal with extreme weather, such as flooding and requirements to support other services within the trust if appropriate.

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.

Summary

We found that the effectiveness of the community dental service was outstanding because:

- Services were evidence based and patient focussed. Services were regularly reviewed and audited to ensure the best treatments were available and staff had excellent training opportunities to ensure they were able to offer care to the highest standards.
- Patient outcomes were good, with patients being involved in deciding on desired outcomes. Due to the complexity of the patients treated by the service, it was difficult to create quantitative data related to outcomes, however, patient's comments were overwhelmingly positive.
- Staff worked effectively with other teams and specialities, ensuring patients on complex care pathways received joined up care where ever possible. The service worked closely with general dental providers in receiving and making referrals.
- There was adequate access to information for the service to function effectively. The service had arrangements in place for transporting notes where required between remote clinic sites.
- The service had a robust system for gaining and recording consent. A variety of consent forms were available due to a high number of patients not being able to consent fully. Despite this, the staff strove to gain consent from individuals as well as parents or guardians to ensure that even where a patient lacked capacity to make a decision, they were involved in the process.

Detailed findings

Evidence based care and treatment

- There was a clinical lead and a deputy clinical lead for the service who were qualified and practicing dentists. They ensured best practice guidelines were implemented and maintained in all areas of the service. For example, conscious sedation, special care dentistry, children's dentistry and in public health and education.
- Patients' needs were assessed on an individual basis to establish their individual care goals. Care was planned and delivered in line with evidence based, best practice in line with national standards. This was supported by patient records and care plans observed in all the clinics we inspected.
- General anaesthesia and conscious sedation were delivered in line with the standards set by the Royal College of Surgeons and the Royal College of Anaesthetists in the document 'Standards for conscious sedation in the provision of dental care' (2015). Patient records showed evidence of the safe care and management of anaesthetised and sedated patients.
- The service followed guidelines set out by the National Institute of Clinical Excellence (NICE) in the provision of dental care. Recall intervals between routine appointments were in line with the standards set out by NICE. Other relevant national guidelines were followed, for example, the British Society of Disability and Oral Health (BSDOH) and the Department of Health Better oral health toolkit.
- Rubber Dams were used in root canal treatments where appropriate in line with best practice guidance and staff were trained in the use of this equipment. These are latex free sheets that protect patients from dental debris and keep the area of treatment free from saliva.

Pain relief

- Pain was assessed on an individual basis. Staff told us that often patients would not be able to provide a pain score, or specifically describe pain. In these cases, staff would monitor behaviours, facial expressions and sounds made as well as clinical observations to assess pain. Although this approach was subjective, staff felt that it was the most effective way to measure pain in patients that could not communicate.
- Pain was managed during treatment with local anaesthetics. Where appropriate, patients were issued with prescriptions after treatment for appropriate analgesia. Where patients had complicated medical histories or were taking strong analgesia routinely, patients were referred to their GP's for further advice.

Outstanding

Are services effective?

- Patients told us that they were asked about pain throughout their treatment and felt that it was managed appropriately.

Nutrition and hydration

- Patients having general anaesthesia were advised not to eat for six hours prior to the procedure, as such, nutrition and hydration were important considerations for staff in the management of patients. Patients were able to drink water up to two hours before anaesthesia to ensure they did not become dehydrated. Staff contacted patients or their carers the day before treatment to reiterate this advice.
- Staff told us that where patients had a history of severe pain, they may not have eaten for several days prior to the appointment. Glucose tablets were available for patients who suffered low blood sugar either before or during treatment. Hypoglycaemia reversal medication was also available if required.
- Advice was given on healthy diets verbally, by posters and through formal education from the health education team. This included advice about foods and drinks that could cause tooth decay and the importance of a healthy balanced diet.

Patient outcomes

- Outcomes of patient care were routinely collected and monitored. However it can be difficult to analyse this data and outcomes were no longer benchmarked against other providers as the data collected is qualitative and often gathered from patient feedback rather than individual measurable factors.
- The service considered a positive outcome to be where the treatment plan was fulfilled. Due to the specialist nature of the service, this could take several appointments and positive outcomes could be relatively minor, for example a patient with an extreme phobia having a routine check-up.
- Patient records and patient feedback indicated that treatment plans were being met and patient satisfaction was high, this indicated that outcomes were being met.
- The service participates in local and national audits in relation to treatments given and the nature of the patients particular needs. We observed a thorough audit of outcomes within the service that highlighted the number of patients seen, whether patients had severe learning difficulties, demographic information (age/ sex) and type of treatment given. However, data was only available from April 2011 to September 2014 at this time. This information was used to better design service provision to meet the needs of the patients treated.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their jobs. The service did not currently provide placements for students, so all staff were fully qualified.
- Dental staff were encouraged and supported to take on further training and development. Staff were encouraged to undertake additional professional training and post graduate qualifications in specialist services.
- All dental nurses had passed the national examining board for dental nurse's certificate in dental nursing. Further training in general anaesthesia, dental radiography and other specialisms was encouraged and supported by the service. Staff involved in health education had qualifications and training relevant to their roles.
- Although there was no specific training available for dental nurses working with children, staff were deemed to have the appropriate qualifications and training as part of their core nursing training. The service had a specialist children's dental consultant and dental staff were supported in developing their skills through further training in working with children.
- Staff had annual appraisals where performance and development were discussed. Plans were agreed to ensure staff were up to date with continuing professional development requirements. All staff had received appraisals in 2015.
- Staff were able to take time off to attend training courses that were relevant to their skill levels and staff were encouraged to share their skills with colleagues where appropriate.

Multi-disciplinary working and coordinated care pathways

- The service had excellent multidisciplinary working relationships both within the hospital and externally. The community dental service worked closely with other services in assessing patients and planning treatments. Often patients would be under the care of

several specialisms. In these cases, dental staff would liaise with other staff to ensure that treatments planned did not interfere with their wider care and to discuss expected outcomes where appropriate.

- There was evidence in patient records of effective collaborative working. Where patients had complex health needs, dental staff would contact a patients GP to ensure they were aware of procedures planned and to allow them any input required, for example changes to prescriptions.
- The service maintained close working relationships with school nursing services, health visiting services, learning disability teams and drug and alcohol services to ensure that vulnerable patients were able to gain access to the service and were supported in doing so.
- Multidisciplinary meetings were held quarterly to discuss provision of care on a trust wide basis. If there were specific care concerns, meetings would be arranged as required.
- The service worked closely with primary dental care providers, taking referrals from dentists where a patient required further treatment than was available in a primary care setting.

Referral, transfer, discharge and transition

- There was a clear referral system in place to refer patients to the service. These were developed to ensure efficient use of NHS resources and to make best use of clinic time available.
- Patients who had single courses of treatment from the service, for example sedation or anaesthetic, were discharged back to the referring general dental practitioner. A comprehensive letter, detailing treatments carried out and any other relevant information was sent to the referrer.
- Where information needed to be shared with other specialists, for example a GP, letters were sent, comprehensively documenting assessments, treatments and care plans. This was discussed with patients and carers prior to referral to ensure consent was given to share information.

Access to information

- An electronic patient record system allowed staff to access patient records across all of the trust’s dental sites. Where complete notes were required, the service made use of the trust’s courier service to transfer written notes and X-ray images.
- Notes were made available prior to appointments so staff could be aware of a patients needs and prepare the clinic space appropriately, including selecting appropriate instruments for assessment and treatment.
- All staff had completed information governance training as part of the mandatory training package. Staff had access to further information governance information policies and support via the trust intranet.
- In each clinic we visited, we saw information for patients relating to NHS charges, those who were liable to charges and dental health information on a range of subjects.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There was a robust and effective system for gaining consent from patients for all aspects of care offered by the service. The consent documentation outlined treatment plans, risks and potential complications. There were three stages of consent form. A form for individuals to consent to treatment, a form for a parent or guardian to consent for treatment of a child and a consent form where the individual lacked capacity to give consent.
- All patient records that we observed had recorded that consent had been requested, and signed documentation was provided to support this. Assessment of capacity was recorded in patient records as well.
- Assessment of capacity was carried out by which ever professional required the decision, regardless of clinical grade. Where appropriate decisions were shared with other professionals. An advocacy service was used to help individuals who lacked full capacity to make decisions relating to their care.
- Where a patient lacked capacity and there was no family member or representative to consent to treatment or assessment, dental staff could make best interest decisions. This would be discussed with other health professionals relevant to the patient to ensure the treatment was proportionate and truly in their best interests.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005. To support staff, mental capacity assessment aide memoirs were available in every clinic room inspected and a

Outstanding

Are services effective?

guide book on making decisions was also available in each clinic visited. We observed consent forms which included a guide on assessing capacity and the importance of informed consent.

- Staff told us that even where a patient lacked capacity or treatment had been consented on their behalf, they would try to explain procedures in a manner that they could understand. Particularly with children. Staff told us they felt it important that patients fully understood their treatment and were involved in decision making.

Outstanding

Are services caring?

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

Summary

We found that the community dental service was outstanding in the domain of caring because:

- Patients and their carers spoke highly of the service and this was reflected in the Care Quality Commission comment cards that were unanimously positive.
- Patients, families and carers felt supported and involved in treatment plans and staff were kind, compassionate and respectful at all times.
- People that we spoke with felt that their particular needs and concerns were understood and respected by staff.
- We found staff to be hard working, caring and committed to their work. Staff spoke positively about their work and were proud of their achievements in the care and treatment they offered.
- Staff were familiar with the patient's fears and took the time to reassure and relax them.
- Staff had good understanding of the importance of gaining consent for examination and treatment and understood how to work with people who lacked the capacity to consent.
- Clear explanations of treatment options were given and the benefits of each were explained in language that patients could understand.

Detailed findings

Compassionate care

- Staff understood the special demands that children may have and were supportive and respectful.
- Social, cultural, religious and personal needs were respected by staff and the service as a whole. Staff told us that they liked to be honest and open with children, explaining procedures and treatment fully, so that they were involved in their care.
- Staff interacted well with children and took time to support them in a considerate manner. Appointments were not rushed and staff were understanding that their patients may require more support. Several comment cards specifically mentioned the positive treatment of children, some with challenging behaviours.
- During the inspection we observed staff treating patients with dignity and respect. Staff spoke with patients, not just their carers and spoke in a friendly manner that was appropriate to the patient. We observed staff providing emotional support to family members and advice to carers in a professional and compassionate manner.
- Staff told us of treatment plans that were sensitive to patient's needs, for example, where a patient had a severe anxiety around dental care. Conversations took place in non-clinical areas to reduce patient stress. We were also told of graded exposure to clinical areas and equipment, to ensure patients were as comfortable as possible with the treatment they were to receive.
- Assessments took place in individual clinic rooms, and doors were shut before assessment commenced to ensure privacy and dignity was maintained.
- Where there were delays or complications in treatments, carers and parents were kept informed and staff explained clearly what the issues were. Patients and carers that we spoke with commented on the excellent levels of communication and this was reflected in comment cards that we received.
- A patient told us that staff had been respectful of their privacy and dignity when they had become very upset during treatment. Staff had allowed the patient time to compose themselves before leaving the clinic room and a member of staff had sat with them to help calm them down.
- We observed staff offering emotional support to an upset family member. The family member was invited for a hot drink and offered privacy or company by the member of staff, and meant that the relative received the same excellent levels of care that the service aims to offer its patients.

Understanding and involvement of patients and those close to them

- Where staff were treating children or young people, they communicated with them in a manner that was appropriate to their level. Using language that was easy to understand, explaining procedures and treatments in a clear and simple manner. Conditions were explained in simple terms and staff ensured that patients

Are services caring?

understood the situation as best as possible. Staff told us they were honest and open with children in explaining care plans and treated them as equal in all aspects of care.

- Where children were too young to be effectively communicated with, staff made them feel relaxed and comfortable, playing with children and using distraction techniques.
- Young people with involved in decision making as much as possible. This included decisions around cosmetic issues, oral hygiene and long term care plans.
- Patients and their families were appropriately involved in making decisions about their care and their thoughts and opinions were a central part of the decision making process.
- Staff had access to a telephone interpretation service, and where possible would book an interpreter to attend with a patient for a complex assessment. An advocate service was used to support patients in decision making and to express their thoughts and feelings where they were less able to. If a patient had difficulty communicating, carers or family members would be asked to assist where appropriate. However, staff were learning Makaton, to help patients feel more comfortable and to improve communication.
- Staff provided a range of advice and material to help patients and the people who care for them manage peoples dental health at home. This varied form dietary advice to specialist care and dental hygiene advice.

Emotional support

- Staff were clear on the importance of offering effective emotional support when delivering care. Staff told us they understood the impact that a patient's condition could have on them. If a patient required further support they were referred to the Improving Access to Psychological Therapies (IAPT) service for cognitive behavioural therapy. This was an evidence based treatment program to help managing anxieties, and other conditions.
- Patients were given time and space to relax and feel comfortable in the dental environment. Staff were accommodating to patients and were constantly looking for new ways to make the service more accessible to people with anxieties and phobias.
- We observed positive interactions between staff, patients and their carers. Patients told us they felt safe and supported in the clinics and they felt that staff understood their needs and provided excellent care. Staff told us of the relationships they developed with regular patients and their carers and how they had developed a good rapport which had improved care and treatments.
- Staff adopted a holistic approach to care and treatment, treating patients individually based on emotional, psychological and social needs as much as their medical needs. Staff told us that they treated people rather than problems.

Outstanding

Are services responsive to people's needs?

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

Summary

We rated the community dental service as outstanding in the domain of responsiveness because:

- People's individual needs and preferences were central to the planning and delivery of services. There was excellent continuity of care and patients had choice about treatments.
- Care plans were centred on patient needs and involved input from other service providers where appropriate.
- Services were planned and delivered in line with the needs of the local population. People from all communities could access treatment if they met the clinical criteria of the service.
- The service worked closely with other agencies to improve access for complex patient groups. This included working closely with primary dental care providers, homeless people, prisoners and people who are resident in nursing or care homes.
- Stakeholder involvement was high and the service values the thoughts and opinions of the people it cared for and those who care for them.
- Adjustments had been made to improve access to clinics, and where problems were identified, patient's opinions were sought in how to improve facilities to greater meet their needs.

Waiting times were kept as short as possible and patients with pain or swellings were seen as a priority.

- Patients were effectively triaged, and those with higher clinical need were seen as a priority.
- Complaints and concerns were acted on appropriately and lessons learned were shared effectively. Services were improved as a result of the failings that led to complaints and people who used services were involved in these changes if they wished.

Detailed findings

Planning and delivering services which meet people's needs

- Information about the local population was used to inform how services were planned and delivered by the clinical commissioning group and NHS England. The service had also completed an audit on treatment carried out that recorded demographic information including age range, sex and whether a patient had a severe learning disability.
- The service worked closely with other health and social care providers, commissioners and general dental practitioners to identify patient groups with complex needs or at risk of poor dental health and provide effective and caring treatment for them. The service provided dental care clinics and education in local prisons, for the homeless community and worked closely with substance misuse services.
- Where people's needs were not being met, adequately, their service liaised with staff, providers and patients to discuss how to better meet their needs. We were told how the service had engaged with patients who used wheelchairs prior to investing in handling and moving equipment to ensure it met their needs.
- Facilities and premises were appropriate for the services that were planned and delivered. Where a clinic was upstairs, a lift was provided and there was a plan and equipment available to exit the building in a fire or if the lift broke down. Limited facilities were available for bariatric patients and senior staff told us that this was a consideration when purchasing new equipment to ensure that the service continued to meet the needs of patients into the future.
- There was sufficient space in all clinics for people with mobility problems to access clinics. Doors were wide and clinics were all on one level. Main doors were electric and mobility equipment including hoists were available in all clinics.
- There was sufficient equipment available to treat all patients as planned. The service had invested heavily in equipment and instruments to minimise the impact of equipment getting lost or damaged in transit to the central sterilisation service.

Equality and diversity

- Services and treatments offered did not vary on the grounds of race, religion, sexual orientation or gender. Staff told us they took pride in offering a non-discriminatory service. This was in line with trust policy. The service treated patients of varied backgrounds and

aimed to meet their needs appropriately. Adaptations were made to care plans where appropriate to accommodate patient's religious, cultural or other needs.

- Staff were aware of the Mental Health Act (MHA) 2005 and the impact it may have on their work. The rights of people subject to the MHA were observed and supported. Children and people with varying types of disabilities, were given priority treatment, particularly when patients were in pain or suffering acute swelling.
- All staff were expected to treat individuals equally and be respectful of peoples differing backgrounds, needs and preferences.
- Staff had completed training in diversity and equality.

Meeting the needs of people in vulnerable circumstances

- The service delivered dental health education and provided treatment to people with several different types of complex needs. The service worked closely with the prison service, providing education and support to prisoners at several facilities across the region. This included routine assessment as well as more complex treatments. The service also worked with the homeless community and substance misuse groups to improve education of dental hygiene, provide support and improve their access to dental care.
- Where patients were living with dementia or had learning disabilities, the health education team provided support and guidance in residential homes and day centre environments. They offered support and education to patients and their families or carers to ensure services were available to all people who would benefit from their use.
- The community dental service offered domiciliary care for patients who cannot leave their home and unable to attend a dental clinic or hospital. Routine assessment and minor treatments were carried out. Where more complex care was required, the service liaised with local patient transport services to help convey patients to appropriate care sites.

Access to the right care at the right time

- The service monitored waiting times, time to first assessments, nonattendance rates and cancellation rates.
- Patients referred to the service are seen within six weeks of the initial referral. Follow up appointments are within 10 weeks and consultant appointments are within 18 weeks of initial referral. Senior staff told us that patients who were in pain or had acute swelling would always be seen by a dentist where possible. If this was not possible they would be referred to the out of hours dental service or an appointment would be made for the next day.
- Appointments were agreed with patients and carers to be at a time and location that meets patients' needs. Staff were accommodating and understanding that some patients may only be able to attend with assistance from carers or family and this is taken into account.
- Staff would contact patients if cancellations occurred and their appointment could be bought forward. This minimised wasted time and allowed patients to be seen sooner. Where waiting times were prolonged, patients were given advice or prescriptions for medication, to manage symptoms or reduce pain. Staff encouraged patients to get in touch if symptoms changed or further support was required.
- Trust data showed an average cancellation rate across the five sites of 19.9%, for the period July to December 2015. This ranged from 15.93% at Harrogate to 22.19% at York. Staff told us there were several reasons for this, but the complex clinical needs of patients and high levels of anxiety was a big part of this. Patients and carers were reminded by text message or phone call on the week of their appointment. Where a patient did not attend and had not contacted the clinic, the clinic would attempt to make contact and re-arrange the appointment. If this was not possible, letters would be sent to a patient.
- Where non-attendance was a safeguarding concern, this was referred to the trust safeguarding team and contact would be made with other services to see if any themes had developed.
- Senior staff told us that children with dental emergencies and people with severe pain or acute swelling would always be seen where possible. The service ran an access clinic in York that provided a walk in centre for any patient with dental issues, varying from routine assessment to urgent treatment.
- Management staff and clinical staff told us that services generally ran on time. Where a particularly complex case arose and a clinic over ran or was expected to overrun substantially, waiting patients were made aware. Those

with later appointments were contacted if possible to rearrange appointments. If there was more than one dentist working then the unaffected dentist would try to see other patients to reduce waiting times. However, we were assured by staff and patients that this rarely happened and most clinics were effectively timed.

- Where an appointment had to be cancelled or delayed, then a new appointment was made as soon as possible, at a time and location suitable to the patient.

Learning from complaints and concerns

- Information was displayed, in every clinic inspected, outlining how patients, their relatives and carers could raise concerns and complaints.
- There was a comment card system, where patients could anonymously raise concerns or thank staff. Patients that we spoke with were satisfied that they understood how to make a comment or complaint if required. One patient told us that they had raised an issue with staff, and staff were understanding, supportive and dealt with the problem straight away.
- Where a complaint was made, staff would try to resolve the issue at the time. If this was not possible then a senior member of staff would contact the complainant as soon as possible, either by phone or by letter to discuss their concerns and to explain the complaints process. Complainants who wanted to take their concerns further were supported to do so and were advised of who to contact for further support.
- Senior staff told us that complaints were handled in a polite, professional and supportive manner. Staff told us that the service did not receive many complaints, so when they did they made a strong effort to resolve issues quickly and effectively.
- Staff had a good understanding of duty of candour and how this related to them.
- Formal records of complaints were kept, and complaints were discussed in local meetings and if appropriate in wider service level meetings.
- Following an investigation, findings would be shared with the complainant and they were asked if they were satisfied with the outcomes. Senior staff told us that the opinions of patients were valued, where complaints were unfounded, staff still wanted to please the patients to maintain their good reputation. Findings were shared in an open and honest manner and staff followed the duty of candour, apologising for failings where appropriate.
- Where a complaint identified a need to make improvements this would be actioned straight away, with information sharing through local meetings as well as service wide governance meetings.

Outstanding

Are services well-led?

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

Summary

The community dental service was rated as outstanding in the domain of well led because:

- There was a clear vision and strategy within the service. Staff were aware of their role in this strategy and understood how this tied into trust wide vision and strategies of "Excellence every time".
- There was a strong governance framework which ensured responsibilities were clear and that quality, performance and risks were understood and managed effectively.
- Staff and patients told us that the service had a good, supportive culture with strong leadership. Staff and managers felt well connected to the trust and the leadership of the Board despite the large geographical area covered. Staff felt respected, valued and an important part of a wider team.
- Although senior staff told us that they had struggled with engagement with stakeholders and patients, we found that the service had engaged well with service users, having sought out and acted on feedback and encouraging participation on an individual and wider level from all stakeholders.
- The service had a culture of continuous improvement and innovation. The service had a number of ongoing projects to improve the care offered to patients and staff were involved in these at all levels.
- From speaking with staff members, it was evident that the service had a forward thinking proactive leadership team.
- Staff told us that they were proud to work for the service and that achieving high levels of patient care was important to them.

Detailed findings

Service vision and strategy

- The trust had a clear vison and set of values and this was carried through to the community dental service. The vision was "Excellence every time" there are also strategic objectives focussing on the delivery of high quality care, effective integration and clinical and financial sustainability.
- Although the vision and strategy were trust wide, they applied closely to the goals of the community dental service that had aims of achieving excellent dental care for all patients in a sustainable and effective way.

Governance, risk management, and quality measurement

- The service held quarterly governance meetings that reported to the Trust Board. The clinical leads reported risks, incidents and complaints to these meetings to bring concerns to a higher level if they could not be managed at a service level.
- The community dental service had no issues on the trust risk register and issues reported on the service risk register had been addressed and were being monitored.
- We saw evidence that serious incidents were reported appropriately via the trust electronic incident reporting system. The service had a strong culture of incident reporting and incidents were investigated appropriately for learning opportunities and to prevent recurrence where possible. Where appropriate, learning was shared with other services. Senior staff told us that they had close learning links with maxillo facial surgery due to similarities in their working practice in general anaesthesia.
- We observed minutes from the August 2015 governance meeting, where infection control, complaints and lessons learned were standing agenda items.
- Recent performance monitoring information was not available so this could not be reported on. However, senior staff explained that this was due to the difficulty of creating quantitative data from the varied treatments offered. We were advised that outcomes were considered to have been met successfully if treatment plans were fulfilled. However information relating to how often this did not occur was not available. Staff told us that care plans were "almost always" met.

Leadership of this service

- The service used team leaders in each of the four localities who were responsible for the day to running of

the clinics. They were also responsible for reporting information to trust managers and feeding information back to clinicians and dental nurses on a one to one or team meeting basis.

- A clinical lead and deputy clinical lead were responsible for the safe implementation of policies and procedures in relation to infection control, managing medical emergencies and incident reporting.
- Staff told us that they felt valued in their roles and on three separate occasions we were told that the service was like a family. Nursing and dental staff told us that the leadership team were approachable, visible and supportive. We were told that the team leaders and clinical leads were very much part of the team and that staff worked together well.
- Staff and managers told us that they had a good relationship with the trust management team. Members of the board had visited dental clinics across the trust and staff told us that they were approachable and that they felt supported by the board. Staff told us that although they were geographically removed from the main hospital site, they were proud to be a part of Harrogate District Foundation trust, and felt that they were a valued part of the wider team.
- Clinicians told us that the clinical lead and deputy clinical lead were approachable and supportive. Staff were encouraged to develop professionally.

Culture within this service

- The service had a strong culture of continuous learning and development. All staff we spoke to had undergone extra training and had plans to continue their development. The service supported staff in this development.
- Staff who were undergoing training told us that they hoped to stay with the service after their training was complete due to the positive environment within the service.
- Staff told us that the working environment was respectful of all staff, regardless of role and that staff felt valued in their work.
- Comment cards from patients highlighted the positive environment and staff, with one parent saying that the “quiet, friendly atmosphere” was ideal for her son.
- Staff were proud of the service they offered and told us they took pride in the work they did. The service was patient focussed and staff reflected this.
- There was a low turnover of staff and many of the staff had been with the service for a long time.

Public engagement

- It was apparent from speaking to staff and service users that the community dental service worked closely with the individuals it served. Due to the complex and specialist nature of the work carried out, decisions were made in conjunction with patients and carers. This included decisions about treatment, care and ongoing needs.
- Senior staff told us that they had consulted with patients with mobility needs to assess which methods of handling and moving were most appropriate, including the use of emergency rescue chairs for descending stairs in a fire situation.
- We received 25 responses to CQC comment cards about the service. All cards were positive and the majority commented on the friendliness and accessibility of the service.

Staff engagement

- All levels of staff attended staff meetings and attendance levels were good. The service tried to engage all members of staff by ensuring that meeting were held regularly and involved all clinics. Service wide meetings were held annually.
- Information was shared via the staff intranet and email to ensure all staff were up to date with changes and developments in the service.
- Staff told us that they were encouraged to speak up with ideas or concerns and that they had been involved in changes that affected them, for example rota changes.
- A full range of staff attended a community dental service visionary event, to look at service improvements and innovations.
- The trust issued a bulletin via email and this allowed staff to keep up to date from remote sites.

Innovation, improvement and sustainability

- The service had recently recruited two specialists in paediatric dentistry and a consultant in special care dentistry to develop the skill mix within the dental team. As patient’s dental and medical requirements become more complex so does the range of clinical expertise the service needed to offer to meet the needs of the patients seen. Specialist posts would advance the range of skills to achieve this. The new clinical commission

Outstanding

Are services well-led?

guides and patient pathways that had been developed also detail the need for specialist and consultant led treatments along with consultant led managed clinical networks.

- The service had also sent out an audit assessing how dental clinics met disability discrimination act building guidelines. A list of requirements had been forwarded to the estates management team to action through NHS property services.
- A digital X-ray system business case had been started. This would allow the service to move to totally digital record keeping, improving the ability to share and quickly recall information.
- A dental team newsletter had been developed to better share news and information with staff and improve communication between sites and localities.
- Senior staff told us that financial constraints had limited the level of care the service could provide. Staffing levels meant that the service had longer waiting times than they would like.