Leeds Community Healthcare NHS Trust

RY6

Community dental services

Quality Report

CQC Registered Location - Head Quarters
CQC Location ID - RY6X6
Tel: 0113 220 8500
Website: www.leedscommunityhealthcare.nhs.uk

Date of inspection visit: 24-27 November 2014
Date of publication: 22/04/2015

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

Summary of findings

Ratings

Overall rating for Community Dental Services	Good
Are Community Dental Services safe?	Good
Are Community Dental Services effective?	Good
Are Community Dental Services caring?	Good
Are Community Dental Services responsive?	Good
Are Community Dental Services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

The community dental service at Leeds Community Health Services NHS Trust met the needs of patients and overall we rated the service good.

At the time of the inspection, we judged that the service was safe and people were protected from abuse and physical harm. We judged he service was effective and that people's care, treatment and support achieved good outcomes for them. Treatments were based on the best available evidence and the service provided good health promotion.

We judged that people were involved in their care, and were treated with compassion, kindness, dignity and respect. The service was responsive to people's needs, specifically meeting the needs of patients who were vulnerable and /or suffered from very poor oral health. The service was well-led in that the leadership and management of the service provided a platform on which a holistic pattern of oral health care could be provided.

In coming to these judgements we spoke with patients and carers, and staff who worked in the community dental clinics. We also inspected the facilities in three clinics (50% of the trusts dental locations) at Seacroft Clinic, Yeadon Health Centre and Armley Moor Health Centre, and observed treatments and care being undertaken, as well as examining clinical records. We spoke with eleven patients and relatives, and observed eight patients receiving dental treatments. We also examined eleven clinical patient records. We spoke with twelve members of staff.

Summary of findings

Background to the service

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The community dental service provides a dental service for the people of Leeds and surrounding areas. The service specialises in the care and treatment of adults and children who have physical, sensory, mental or medical impairment. It also provides services for people who are dental phobic, those who are homeless and people in prison. As part of the service it provides dental treatments under general anaesthetic, for adults and children, in partnership with Leeds Teaching Hospitals NHS Trust.

The general and specialist dental service is based at six clinics in Leeds, whilst procedures under general anaesthesia are undertaken at St James's University Hospital, for adults, and at Leeds General Infirmary, for children.

In addition the service undertakes epidemiological studies into the health needs of specific groups within the local population. Epidemiology is concerned with the study of the patterns, causes and effects of health and disease conditions in defined populations. They also provide oral health promotion advice to children and vulnerable groups in the Leeds area.

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Leeds Community Healthcare NHS Trust was inspected as part of CQC's inspection programme. The trust is also seeking to become a foundation trust. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services

Before visiting, we reviewed a range of information we hold about Leeds Community Healthcare NHS Trust and

Summary of findings

asked other organisations to share what they knew about the provider. We carried out an announced visit between 24 and 27 November 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/ or family members and reviewed personal care or treatment records of patients. We visited 29 locations which included 3 community inpatient facilities. We carried out unannounced visits on 26 November to the twilight service and child development services.

What people who use the provider say

We spoke with eleven patients, relatives and carers, and observed eight patients receiving care and treatment.

We found that patients, their carers and relatives, were involved in their care. People who used the service were also treated with compassion, kindness, dignity and respect.

Good practice

Our inspection team highlighted the following areas of good practice:

N/A

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that the numbers of staff receiving infection prevention training is improved.
- The trust should ensure that all patients are provided with the appropriate treatment plan.

Leeds Community Healthcare NHS Trust

Community dental services

Detailed findings from this inspection

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

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Summary

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There were systems in place for reporting incidents, and learning from them so as to improve service provision and safety. There was good records management with the exception of the clinical records of one dentist which were found not to have been fully completed. However, senior staff told us they would ensure these instances of poor record keeping were brought to the attention of the dentist.

Staff we spoke with were knowledgeable about safeguarding procedures. From evidence reviewed 94% of staff had received children's safeguarding training and 98% of staff had received adults safeguarding training.

Trust records indicated that the community dental service had only put 83% of their staff through infection control and prevention training, against a trust target of 100%. Overall, there were satisfactory systems in place to ensure cleanliness; infection control and hygiene were maintained.

Detailed findings

Incident reporting, learning and improvement

The community dental service reported 32 incidents to the National Reporting and Learning Service (NRLS) between 18 September 2013 and 17 September 2014. Of this number four were recorded as being of 'low harm' whilst 28 were recorded as being of 'no harm'.

Incidents were reported on the trust's intranet using an incident reporting form. As part of this process it was recorded on the Datix reporting system, a nationally recognised electronic system for the reporting of safety incidents. Staff we spoke with gave us an example of how an error involving the loading of x-ray film was reported on the system, with learning discussed at team meetings. A 'service learning memo' was also produced to remind staff of the correct procedures in such circumstances. In this particular incident no patients were put at risk.

Duty of Candour

Staff we spoke with were aware of their duty to report any incidents which might affect patient and staff safety, and to ensure patients and their families were kept informed. Although there were not any incidents

which would have triggered the actions expected under the Duty of Candour there was a complaint from a patient

which was dealt with in a similar manner. In this case the carer of a patient with autism complained that staff were not trained or knowledgeable enough about autism spectrum disorders. This directly led to the staff being sent on a specialist course which dedicated to teaching them how to respond to people with autism.

Safeguarding

All staff we spoke with were aware of their responsibilities to report any potential safeguarding incidents, and were aware of whom to report such incidents, and how they were investigated by the trust and local safeguarding bodies. Staff were trained up to level two in the safeguarding of adults and children.

Staff we spoke with were knowledgeable about safeguarding procedures. From evidence reviewed 94% of staff had received children's safeguarding training and 98% of staff had received adults safeguarding training.

Medicines management

Medicines, including oxygen, used for dental care and emergency situations were appropriately stored. There were checklists which staff completed on a daily basis to ensure they were in date and ready for use.

Safety of equipment

Regular checks were made of the equipment used in the clinics. However, at the Seacroft clinic we found that the compressor, which was used to power the dental drills and other devices, was not functioning properly with no air cooling or drying of air. Although this would not affect patient safety it required attention. We informed senior staff in the clinic who told us they would ensure the compressor was repaired.

Records and management

The clinics used an electronic patient database called System of Excellence (SOE) for entering patients' dental care and treatment. This would either be completed directly or data would be recorded on hard copy and entered at a later date. Staff told us that although the system was suitable for day to day clinical work in the department it was difficult to extract clinical outcome measures. Clinical outcome measures are used amongst other things as a basis for auditing clinical practice and benchmarking against other similar services. The clinical managers of the service told us that work was being done to make it easier to extract. The community dental service review stated that part of this improvement work included ensuring staff used the "case mix tool" on SOE. It also said that although dental services were not part of the Electronic Patient Record (EPR) project that any benefits from it could be used by the service.

However, it was possible to use the system to enter basic periodontal examination (BPE) scores which were a record of the health of patients' gums. We observed BPE scores being entered directly onto the electronic database by dentists during the course of their patient examinations. We also found that dentists would make clinical observations which were recorded on paper records by the dental nurses assisting them. These were later added to the SOE database. Hard copy records were used to store appointment discharge and referral letters. Radiographs and traceability stickers for clinical equipment were also stored in the hard copy paper record.

We examined eleven sets of clinical records kept on the SOE database. Overall the standard of report keeping was accurate with all necessary clinical and other information appropriately completed. However, we found that one dentist had failed to justify, report and grade every radiograph taken. In the interests of patient safety and clinical accountability the dentist should record such information. They had also not recorded their discussions with the patient, including what treatment options were available to them and their decisions as to their treatment. Discussions as to patient choice should be recorded in the record. This was noted on three of the eleven electronic records we reviewed. We reported this to a senior member of the team who told us they would escalate the matter for investigation.

Cleanliness, infection control and hygiene

The decontamination of dental instruments was undertaken by a private company contracted by the trust. The instruments were taken away in sealed boxes and later returned by the company. They would inform the trust of any damaged instruments or any other matters of concern. The quality of the work undertaken was audited by dental nurses. However, although there was a system for tagging the boxes to mark which was a dirty box and which was a clean one all the boxes, both clean and dirty, were of the same colour. It would not be inconceivable that errors could occur because both clean and dirty boxes were of the

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Are services safe?

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same colour, notwithstanding the tags used on the different boxes. We discussed this with senior dental nursing staff who were confident that their systems were safe.

There was a traceability system using barcodes which allowed a record to be kept on all dental instruments sent for decontamination. During our visit we observed an employee of the contractor collecting an appropriately sealed dirty box for contamination at their off-site facility.

Whilst the clinics were cleaned by general domestic cleaning staff the clinical areas were cleaned before and after their use by dental nurses. There was also a cleaning service available to do 'spot' cleans when required; this being the cleaning of an area after a spillage. We saw clinical staff observing hygiene precautions whilst treating patients in the dental surgeries, including using masks and visors. Patients and their relatives told us that staff always wore masks and visors, and provided them with disposable bibs and glasses to protect their eyes and prevent splashing onto their clothes.

Infection control was audited by the trust's infection prevention and control team, which was not directly connected with the community dental service and allowed for an element of independent oversight. Infection control and prevention training of staff in community dental services was at 83% against a trust target of 100%.

There were systems in place for the safe removal of clinical waste from the community dental service clinics.

Mandatory training

Staff we spoke with told us they were updated on a regular basis with mandatory training. We reviewed the training records of a dental nurse we spoke with and they showed that they had received resuscitation training in February 2014, fire safety training in April 2014 and manual handling training in June 2014.

Trust records we reviewed showed that of November 2014 the following percentage of staff completed "Universal Statutory and Mandatory Training" against a trust target of 100%:

Equality and diversity – 91%

Fire training – 98%

Information governance – 98%

Infection control and prevention – 83%

Slips, trips and falls – 95%

Assessing and responding to patient risk

We found that both adult and paediatric patients who required dental procedures under general anaesthesia were appropriately assessed by the clinical team. This included, in cases where it would be particularly distressing for the patients to come into a clinic to be assessed, they were assessed in their own home environments. This occurred on eight occasions over the last year. General anaesthetic procedures were carried out at the Leeds Teaching Hospitals NHS Trust; with adult patients being treated in the David Beevers Day Surgery Unit at St James's University Hospital in Leeds, whilst children were treated in the Clarendon Wing Theatres of Leeds General Infirmary. The anaesthetics were undertaken by consultant anaesthetists who were assisted by qualified Operating Department Practitioners. This ensured there was a safe clinical environment with the critical care facilities of the two hospitals available in the event of any serious clinical incident.

Staffing levels and caseload

Managerial, supervisory and clinical practice staff we spoke with felt that the staffing numbers were sufficient to provide a safe working environment for patients. We were told that they had just appointed a new full time dentist and were in the process of recruiting another part time dentist. The staffing establishment had been reviewed as part of a trust wide service review which was undertaken to ensure they could manage their services within a reduced financial template. Work on the proposal was still continuing with completion of the project expected in February 2015. Therefore the staffing establishment we examined was that in place at the time of the inspection, in November 2014.

We found an establishment of 9.33 whole time equivalent (wte) dentists. There was a 0.65 wte dental consultant who specialised in paediatric dentistry and led the clinical service. There was a variance against establishment of 0.5 wte dentists. The service was in the process of recruiting a part time dentist.

There was an establishment of 21.62 wte dental nurses, which included four dental therapists (3.40 wte). Of this establishment there was a negative variance of 0.90 wte for

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In the three clinics we visited we found there were sufficient staff in all clinical areas. However, at the Seacroft clinic a dental nurse was working as a receptionist, which is an administration and clerical post. This was a result of the variance against establishment of 0.35 wte, sickness and annual leave. A capacity and demand exercise undertaken by the trust as part of the dental services review showed that clinical staff were seeing on average 12 patients per day in clinic. The analysis concluded that increases in clinic size and a decrease in the DNA (did not attend) rate would allow the same number of clinical staff, or a reduced number of clinical staff, to see more patients thus increasing productivity. Although the review was not fully completed this showed that the trust was engaged in an exercise to ensure that staffing levels met the patient caseload.

Managing anticipated risks

We found that all staff had undergone training in resuscitation procedures for the immediate management of cardiac arrest, anaphylactic shock and other sudden medical emergencies. The clinics contained emergency drugs, oxygen, an ambu bag and an automated electronic defibrillator (AED), suitable for both adults and children. An AED is an automated defibrillator which assists staff with recorded commands in order to shock patients in ventricular fibrillation back into a normal heart rhythm.

We spoke with dental nurses who explained how dental emergencies such as bleeding sockets were managed. As has been described above, systems and policies were in place for the safe management of general and sedative anaesthetics. We observed these systems and policies being followed whilst a patient was undergoing a procedure under sedation.

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Are Community Dental 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 judged that services were effective in that people's care, treatment and support achieved good outcomes, provided a range of health promotion and was based on evidence.

The service followed National Institute of Health and Social Care Excellence (NICE) guidelines. Pain relief was provided in the form of local anaesthetic injections, whilst inhalational sedation and general anaesthesia were used when required. We found during our observation of treatments undertaken by dentists and a therapist that they followed best clinical practice. Whilst some systems for monitoring and reviewing patient outcomes, mainly through epidemiological studies, were in place others were in the process of being developed.

We found that on average 90% of staff received an appraisal within one year, and their personal development was supported.

There were systems in place to allow high street dentists and other professionals to refer patients to the service.

Although there were systems in place to allow patients to give their consent we found that treatment plan and estimate plans were not always provided to patients as was required. These forms show patients what treatment they have received or are about to receive. For patients who did not have the capacity to consent staff were aware of their responsibilities under the Mental Capacity Act to act in the best interests of patients and to formally document that.

Detailed findings

Evidence based care and treatment

The service followed NICE (National Institute for Health and Care Excellence) guidelines. We reviewed evidence of this in regard to NICE guidelines for antibiotic prophylaxis, the removal of third molar teeth, and risk assessments of patient recall periods. We found during our observation of treatments undertaken by dentists and a therapist that they followed NICE guidelines where relevant, and best clinical practice. Staff we spoke with were aware of NICE guidelines.

Pain relief

When required the dentists and therapists would use injections of local anaesthetic pain medicine. In certain appropriate cases they would use a technique involving a combination of oxygen and nitrous oxygen, called relative analgesia (RA), to sedate the patients and help them relax. When clinically indicated a general anaesthetic procedure was used. Patients, who had difficulty with dental procedures in high street practices, including those who were nervous and had a low pain threshold, were treated by specially trained practitioners using sedation techniques.

Approach to monitoring quality and people's outcomes, Outcomes of care and treatment

From August 2013, following the dental services review, the trust had collected some quality metrics and measures as part of an ongoing quality impact assessment. These included measures of clinical effectiveness. However, although two outcome measures, the recording of BPE (basic periodontal examinations) and of the risk of developing dental caries were undertaken, no results against trust baselines were available to the inspection team. It was noted earlier in this report that work was taking place nationally to create ways of measuring clinical effectiveness in dental services. We were also informed that the trust intended to use their Software of Excellence (SOE) database to record this information.

However, results for quarter one of 2014 were available for public health targets. The service was commissioned to provide a public health service in the field of oral health. The measures included the increase in the number of schools and children's centres taking part in tooth brushing schemes. Against an expected rise of at least 10% the service had produced a 25% increase. With regard to the increase in the number of children taking dental milk the increase was 33% against the 10% target.

As well as delivering these outcome measures the community dental service used them as a guide as to where interventions were needed in the provision of services to "hard to reach groups". This is seen in the work

they undertook in providing dental health advice and treatments to vulnerable and disadvantaged children, and to homeless people and people with drug and alcohol problems.

Competent staff

Trust records showed that throughout 2013 the community dental service had met or exceeded the trust's target that at least 90% of staff should have received a yearly appraisal. However, this dropped in February 2014 when performance was at 88%. The community dental service review explained that this was due to changes in senior management at this time, and it was in this particular area where there was a downturn in performance. Staff we spoke with told us they received regular appraisal which included a personal development review. In the case of dentists we found that all dentists were appraised by a dentist of a higher grade.

As part of their development, dental professionals; including dentists, therapists and dental nurses must undertake continuing professional development (CPD) to maintain their professional registration. We spoke with a dental nurse who told us, and showed evidence of, their attendance at training courses and in the reading of professional journals. This included attendance on a radiation safety update course in April 2014. They also told us that as part of their development they had undertaken a course in dental sedation and now specialised in this area.

The community dental services review reported that only 60% of staff had received clinical supervision in the last quarter of 2013/14. However, staff we spoke with told us they received regular clinical supervision, which was undertaken on a quarterly basis.

Multi-disciplinary working and coordination of care pathways

Staff in the service worked as part of a multi-disciplinary team. Patients were examined, assessed and treated by both therapists and dentists, who were assisted by dental nurses. There was also multi-disciplinary working with the operating theatre services of the Leeds Teaching Hospitals NHS Trust, where the dentists undertook procedures on adult and paediatric patients who had received a general anaesthetic. The general anaesthetic service was delivered by specialist consultant anaesthetists employed by the teaching trust.

In the case of general anaesthesia there was a care pathway which involved both dental and anaesthetic assessments, followed by the substantive procedure. Further care and treatment was continued until the patient was discharged back to the care of their general dental practitioner (GDP).

Referral, transfer, discharge and transition

In all cases patients were accepted for treatment from referring general dental practitioners, general practitioners (GPs) or other health or social care professionals. On the completion of their care and treatment they were discharged back to their referring practitioners. Referrals were made directly to the community dental service office at the Middleton Clinic in Leeds. These referrals were then triaged, allocated to a clinic and the patient offered an appointment. Inappropriate referrals were returned to the referrer.

Appropriate referrals were patients with a learning disability, including those with challenging behaviour, persons who were medically compromised or had a severe physical disability, and those with a mental health condition. The service treated vulnerable and socially disadvantaged children, including looked after children. There was also an inhalational sedation service, relative analgesia (RA) for highly anxious patients, in addition to the general anaesthesia service.

There was no transition service as the community dental service treated both children and adults in a seamless process.

Availability of information

In order to ensure efficient and effective referrals the service provided a document entitled "information and guidance for referrers". We reviewed this document, which gave concise details on what was an appropriate referral and where to make that referral.

A guide to community dental services was provided to patients which included information on how the appointment system works, and the contact details for the clinics. A similar leaflet which used a combination of pictures and text was also available for people who had a learning disability.

Consent

Good

Are Community Dental Services effective?

Overall there were appropriate systems in place for consenting patients for their treatment. We observed dental procedures undertaken by both dentists and hygienists where, following an examination, an explanation was given as to what was required and why. Where there were different treatment options these were explained to the patients. The patient's decision was then recorded in the electronic record by the dentist or therapist before treatment commenced. However, an examination of the clinical records found that one dentist did not record their conversations with the patients as to the available options, nor did they record the patient's consent. We reported this to senior staff on duty who told us they would follow this up with the dentist concerned.

The service did not routinely provide treatment plan and estimate forms to patients. These forms show patients what treatment they have received or are about to receive. It is a requirement that all patients receiving NHS care must be given a form when they receive Band 2 or Band 3 dental treatments. One should also be given if requested in the case of Band 1 treatments. Band 2 treatments are fillings, root canal work and dental extractions; whilst Band 3 work includes crowns, dentures and bridges. Band 1 work is examination, diagnosis, and scale and polish, and other similar treatments.

Where general anaesthetic procedures were concerned a written consent form was completed. This included sections covering details of the proposed dental procedure, as well as a section which was completed by the anaesthetist to say they had explained the benefits and risks of anaesthesia to the patient. The form was then signed by the patient, if they had capacity to do so, or if a child had the necessary understanding to do so. There were specific forms for adults who were unable to consent to treatment, and for children or young persons. The form for adults who did not have the capacity to consent included a section which the clinicians completed to show that an assessment of the patient's best interests had been made.

In the case of adults who did not have capacity procedures to assess capacity and decide on the patient's best interests were in place. These included the holding of 'best interest meetings' and the use of an Independent Mental Capacity Advocate (IMCA). These procedures were undertaken under the terms of the Mental Capacity Act (MCA) 2005, and the related Deprivation of Liberty Safeguards (DOLs). We reviewed the MCA forms used as part of this process, which included guidance on the Act for the clinicians. These were the appropriate forms and were readily available and understood by staff.

All staff we spoke with had a good knowledge of the Mental Capacity Act both in theory and how it was used in practice in their service. Staff had also undergone training in the Act, and related procedures.

Good

Are Community Dental Services caring?

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

Summary

We spoke with eleven patients, relatives and carers, and observed eight patients receiving care and treatment.

We found that patients, their carers and relatives, were involved in their care. People who used the service were also treated with compassion, kindness, dignity and respect.

Detailed findings

Dignity, respect and compassionate care

The patients, relatives and carers we spoke with told us they were treated with dignity and respect, and received compassionate care. We were told by the parent of one young child that dentists they had seen previously to coming to the community dental service had been unable to get them to relax sufficiently enough to receive dental care. However, on the first visit the staff in the surgery had gained the child's trust and got them to relax in the chair and allow themselves to have a dental examination. Staff told us this was possible because they allowed more time for patients than was available in high street general dental practices.

All the people who received a service we spoke with told us that staff were always sensitive in the care they offered. The carer of a patient with a learning disability told us that staff always took time to ensure the patient was able to open their mouth fully, as they had great difficulty doing so. They told us that when doing so staff behaved in a very compassionate way.

We spoke with a patient who had a mental health condition who told us they were always treated with respect.

Patient understanding and involvement

Dental sensory packs were provided to children, including those with autism, who attended the clinics. These contained toothbrushes, toothpaste and face masks, as worn by the dental staff. The intention was to allow the children to gain more understanding of the service and to help them lose any fear they might have of going to the dentists.

Emotional support

Staff told us that as the core work of the community dental service was to provide care and treatment for people with physical and mental health needs, and with a learning disability, it was part of their role to provide emotional support. This was noted in the interactions seen between the staff and the patients, not only in the dental surgeries, but in their interactions with them in the clinic. In one of the clinics a carer had told us how impressed they were by the support offered by the reception staff.

Promotion of self-care

As part of the health promotion work undertaken by the service we found that dental nurses would go out to schools to teach children in deprived areas how to clean their teeth and promote their oral health. This was also undertaken with people who had a learning disability.

Good

Are Community Dental Services responsive to people's needs?

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

Summary

Services were responsive and were organised so as to meet patient's needs. There was an ongoing service review which had examined in detail the needs of the service and had made recommendations for how it could best meet people's needs moving forward.

There were systems and processes in place to meet the specific needs of people who were vulnerable, and to provide translation and interpretation services for people who did not speak English, or who used sign language.

The community dental service met the government's 18 week referral to treatment target for patients who required a general anaesthetic.

There were systems in place for managing patient complaints and evidence that the service had learned from such complaints.

Detailed findings

Planning and delivering services which meet people's needs

The trust had recently prepared a review of the community dental service which provided various options for the development of the service within a reduced financial template. This review considered the most clinically and cost effective way to provide the service. It stated that the intention of the service was to meet the needs of people with a leaning or physical disability, who had mental health needs, or were otherwise vulnerable. It also stated how it provided a service for people who were dental phobic.

The review concluded that there was a high number of people on the waiting list as a result of an increase in referrals combined with sickness within the service. It was also felt that they were exceeding their contractual targets as negotiated with their commissioners. It stated that work was continuing on these issues.

The review found the service was affected by patients not attending (DNA) or cancelling at short notice. Between April 2013 and March 2014 this was at its lowest in November 2013 when 10% of patients were DNA whilst the highest rate of DNA was in August 2013 when 20.8% of patients were recorded as such. The average was 14%. In order to manage this, the service brought in SMS text messages and reminders. Following this in June 2014 the DNA rate was at 12.8% which was recorded as Amber in the trust's RAG (Red, Amber, Green) risk rating system.

As part of the service's work they were commissioned by Leeds City Council and Public Health England to provide a dental epidemiology programme, a milk fluoridation programme and oral health promotion. Epidemiology is concerned with the study of the patterns, causes and effects of health and disease conditions in defined populations. This will allow a picture of dental health in the Leeds area to be built up which will assist with the development of the service and the calculations of those commissioning the service as to what is required.

Equality and diversity

There was an appreciation by staff of the needs of people who used the service whose first language was not English, or who were profoundly deaf and use sign language. There was access to translation and sign language interpretation services provided by professional translators and interpreters who attend the clinics.

Meeting the needs of people in vulnerable services

Because of its role in providing dental services to vulnerable people there was an understanding of the needs of various different vulnerable groups, including people with a learning disability and those with dementia. This was noted by us in our observations of the way dentists, therapists and dental nurses communicated with and assisted such vulnerable groups.

A leaflet called "my visit to the dentist" had been produced by the community dental service which used a pictographic format to help explain to people with a learning disability what it was like visiting the dentist, and what they should expect.

There were also hoists at all except one of the clinics to assist people with a physical disability get onto the dental chair. In addition to this at the Middleton Clinic there was a specialist "tipper chair" in the dental surgery which was specially designed for people who were confined to a wheelchair.

Good

Are Community Dental Services responsive to people's needs?

Health promotion services were provided on an outreach basis to homeless people in shelters and on the streets. A service which was also provided to vulnerable children in local schools, and to people with a learning disability in care homes. Part of this service involved teaching teachers and the professional carers of people with a learning disability how to give dental health promotion advice.

Access to the right care at the right time

The community dental service met the government's 18 week referral to treatment target for patients who required a general anaesthetic. With regard to patients who did not require a general anaesthetic this group of patients did not come under the ambit of the government target. Although in the interests of equity the service treated all patients as if they did. Trust records showed that between April and November 2014 the average waiting time for a first appointment was 12.3 weeks.

Complaints handling (for this service) and learning from feedback

The community dental service adhered to the trust policies on the management of complaints. Staff we spoke with told us they would try to deal with complaints by trying to resolve concerns that were brought to their attention in the clinics. They would also learn the lessons of complaints which were discussed at team meetings.

In 2013/2014 there were five complaints logged on the Datix complaints' management system. These included appointment waits, the temperature at one of the clinics, and the closure of one of the clinics, at Morley.

In one case a parent had verbally complained that staff in the dental surgery seemed not to be very proficient or well trained in communicating with, or managing the needs of their child who was on the autistic spectrum. The service responded to this complaint by providing their staff with training and education to ensure that they could communicate more effectively with people who were on the autistic spectrum.

Good

Are Community Dental Services well-led?

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

Summary

We found that the service was well-led, in 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. The dedication of staff and the local managers was evident despite some uncertainty resulting from the dental services review. However, we found that there was consultation with staff over these proposals.

Although there were patient satisfaction surveys we felt this was an area of practice which the service could be more innovative with and develop further.

Detailed findings

Service vision and strategy

Staff in the community dental service told us they were aware of the trust vision that all:

- patients have the right to safe, evidence-based and innovative care
- patients should be guaranteed timely access to the most appropriate service for their needs
- staff should have access to relevant training and development which supports them to deliver excellent care
- We work best when we work with our patients, staff and others to develop and deliver services.

We also found printed notices with this vision prominently displayed in the clinics.

The vision was linked to the community dental service strategy that was being developed as part of the dental services review, which commenced in 2013. However, the dental review was also initiated because the trust had to make over the following two years, as well as a further reduction in funding over the next five years. Therefore the review was driven as much by a requirement to work within tight financial strictures as well as to develop the service.

Governance, risk management and quality measurement

Clinical governance is a standing agenda item on all community dental service team meetings. At the senior dental team meeting on 2 October 2014 x-ray and inhalational sedation protocols were discussed. Clinical and corporate governance issues were reported through the specialist services group, which is a part of the medical directorate.

Leadership of this service

There is a lead dentist, supported by operational clinical managers, who report up to the associate medical director for specialist services. Reporting structures then go through the medical director to the trust board.

Staff we spoke with felt well supported by their local managers and supervisors. They also told us they had received visits from the new chief executive and non-executive board members.

Culture within this service

The view we gained about the culture of the service through talking with staff, patients, carers and relatives, was one of a positive caring environment. Staff were aware their core role included providing specialist dental care to vulnerable people and the practice we saw reflected this.

Public and staff engagement

The service had tried to communicate with the public through organising focus groups to discuss community dental services, although attendance was poor. However, a newsletter called 'word of mouth' was produced for people who used the service. A 'guide to our service' leaflet had also been produced which described the service provided and was given to all people who attended the clinics. There was also a guide which had been produced for people with a learning disability.

Good

Are Community Dental Services well-led?

Patient satisfaction surveys were undertaken with forms readily available in the waiting rooms. In 2013/2014 analysis of completed patient satisfaction questionnaires showed positive satisfaction levels between 95% and 99%.

Staff were engaged with through attendance at regular team meetings. As the community dental services review was considering proposals to reduce dental nurse grading and put some staff at risk of redundancy the trust was required to hold consultations with staff and their representatives. We found that this had taken place although there were different views amongst the staff about how inclusive the consultation process had been for them.

Innovation, improvement and sustainability

There were no particular areas of innovation although the dental services review provided evidence that the trust was making efforts to improve the service, and make it sustainable for the future, despite the challenges provided by a reducing budget.