London North West Healthcare NHS Trust

R1K

Community dental services

Quality Report

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Summary of findings

Locations inspected

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for the community dental service of requires improvement because:

- The service did not consistently identify or address potential safety issues. This included risks to patient safety and the secure storage of confidential patient records. The monitoring of safety systems required improvement, as illustrated by our finding of nitrous oxide cylinders that were past their expiry date. There was limited use of systems to report and share learning from incidents and near misses.
- Systems to manage patient records required improvement. There was inconsistent use and availability of software and IT equipment. There were gaps in visible management and support arrangements for staff as managers were based at a different location to the services and had to spread their time across five locations.
- There was a long waiting time to access specialist endodontic and periodontic services. The service did not take into account the needs of the local population when planning services, as there were no leaflets available in languages other than English, despite there being a sizable section of the local population with English as a second language.
- Trust-level management was not visible. Staff were not aware of the trust's vision and strategy.
- Risks were not always managed appropriately or in a timely way. For example, staff raised an issue with a door as a risk to patient safety, but action was only taken after a child sustained an injury. Management presence at the locations was limited. Staff did not always feel actively engaged or empowered and felt remote from the trust.

However,

- We found staff to be caring and passionate about their work. They were hard working, committed and were proud of the service they provided. Staff spent time listening to and talking with patients, or those close to them. They treated people with respect and kindness. Staff communicated with patients in a way they could understand and enabled them to manage their own oral health and care when they could.
- We observed good practice and procedures in place for cleanliness, hygiene and infection control.
- We found that staff had the knowledge, skills and competence to carry out their roles and responsibilities effectively.
- The service was responsive to the needs of patients with physical disabilities, for example hoists were available and staff visited patients who were unable to get to the clinic.
- Most staff we spoke to felt well supported by their line managers within the service.

Summary of findings

Background to the service

London North West Healthcare NHS Trust Community Dental Service provides a dental service for all age groups who require a specialised approach to their dental care and are unable to receive this in a general dental practice. This includes adults with moderate to severe special needs (learning disabilities, physical disabilities, wheel chair users requiring a hoist, mental health patients, patients with a complex medical history affecting delivery of dental care, and housebound patients) and children with learning disabilities, under the care of social services, with dental anxiety or with extensive dental needs due to high decay rate, dental trauma or dental abnormalities.

The service provides treatment under inhalation sedation (a light form of sedation allowing the patient to feel relaxed and accept treatment) and local anaesthetic. It also provides specialist endodontic and periodontics treatment. Endodontic treatment, also known as root canal treatment, is a dental procedure to treat infection at the centre of a tooth. Periodontics treatment is for periodontal diseases which affect the tissues supporting the teeth and can lead to the teeth falling out if not treated.

The service operates at five locations across the boroughs of Ealing, Brent and Harrow. We visited three locations during our inspection: Wembley Centre for Health and Care, Grand Union Village Health Centre and Acton Health Centre. The other two locations are Heart of Hounslow Centre for Health and Alexandra Avenue Health and Social Care Centre.

We observed seven consultations including a visit to a patient's home and a visit to an inpatient at a community hospital. The two visits were adults with special needs. Four consultations were with children accompanied by a parent. Two patients were wheelchair users.

We spoke with 20 members of staff including senior managers, dentists, senior dental officers, dental nurses, senior dental nurses, and administrators.

Our inspection team

Chair: Dr Richard Quirk, Medical Director Sussex Community NHS Trust

Team Leader: Robert Throw, Interim Head of Hospital Inspection, Care Quality Commission

The dental inspection team consisted of a CQC inspector and specialist advisers.

Why we carried out this inspection

The inspection was part of a planned scheduled inspection.

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?

Before visiting the trust we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 19 and 23 of October

Summary of findings

2015. During the visit spoke with a range of staff who worked within the service, such as managers, nurses, and therapists. We observed how people were being cared for and we talked with parents and reviewed a small number of treatment records of people who use services.

What people who use the provider say

Patients, carers and relatives we spoke to were happy with the care they received. The service scored well in the NHS Friends and Family Test and achieved an average of 98% across all locations from May to August 2015. This meant that 98% of respondents said they would recommend the service to a friend or relative. This was better than the national average of 95% for community services in England in September 2015.

Good practice

- Staff were caring and passionate about their work. They spent time listening to and talking with patients, and/or those close to them.
- The service had good practices and procedures in place for cleanliness, hygiene and infection control.
- Staff felt well supported by their peers and there was a strong sense of teamwork.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:

- The provider should ensure the secure storage of all patient records at all service locations.
- The provider should put a system in place to ensure that nitrous oxide and oxygen cylinders are taken out of use once they have passed their expiry date.
- The provider should ensure that mandatory training for staff is up to date.
- The provider should ensure consistent availability and use of computers and software across all service locations.
- The provider should ensure that risks are managed appropriately and in a timely manner.
- The provider should ensure clear communication channels between trust-level managers and the service. They should ensure that service managers are able to provide adequate support to staff at all locations.

London North West Healthcare NHS Trust

Community dental services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

There was no clear system in place for identifying and learning from patient safety incidents. Mandatory training records were not up to date and staffing levels were insufficient. As a result, dental nurses often had to work at different sites to cover absences. There was an insufficient mix of skills across the service, as dental nurses had to cover administrative duties when the administrators were not working, as well as decontamination of dental instruments.

The service did not consistently identify or address safety concerns. For example, an incident occurred where a child trapped their fingers in a door. Staff had identified the door as a risk prior to the incident, but the trust had not addressed this.

There was a patient confidentiality risk at Acton Health where staff did not lock patient records away and the reception area was left unstaffed and accessible to the public.

However, we observed good practice and procedures in place for cleanliness, hygiene and infection control.

Incident reporting, learning and improvement

- There were five incidents reported in Community Dental Services from 1 August 2014 to 31 July 2015. Of these one caused low harm, one caused moderate harm, and three caused no harm.
- The system for sharing learning from incidents within the service and between the service and the trust required improvement. When talking to staff we found little evidence of shared learning from incidents, 'never events' and near-misses ('never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). Staff had heard of incidents but were not aware of action plans and learning points. Some staff told us that the service did not record near misses. This meant there was limited potential for learning from incidents that almost caused harm.
- Some staff we spoke to were unaware of what a never event was, and others were unsure what would be classed as a serious incident. The community dental services did not have a policy about what staff should report as a serious incident. However, some members of staff we spoke to were aware of how to report serious incidents using the trust-wide system (Datix) and were aware that there was a list of types of incident on there.
- There were no 'never events' reported in the service in the 12 months prior to inspection. Some staff and

Requires improvement

Are services safe?

managers were aware of never events and incidents that occurred in the trust relating to orthodontics, but there was no formal method of sharing information and learning relating to this.

- There was an incident at the Heart of Hounslow Centre for Health around one year ago where a child seriously injured their fingers by getting them trapped in a door. Staff told us they had raised the issue with the doors as a risk to managers before this incident, but said that nothing was done. We did not see documents to support this. This might have shown that risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed. After the accident, the centre installed door guards to prevent a similar thing happening again.
- The clinical lead informed us that an incident occurred in 2015 involving accidental radiation exposure during an x-ray. They told us that the incident was investigated and learning was shared. Staff we spoke to confirmed that they heard of this incident. We saw minutes from the Grand Union Village Health Centre meeting in July 2015 detailing the incident with learning points.
- Managers and dentists were aware of the basic meaning of Duty of Candour; however, some administrative staff and dental nurses were not. This meant there was a risk that some staff may not know what was required of them in the event of a patient safety incident and might not follow all the correct steps when dealing with one.

Safeguarding

- We reviewed training records, which showed that all dentists had up to date level three safeguarding training. All dental nurses had up to date level three safeguarding training except for one but the lead dental nurse informed us that this was because they were a new member of staff and had yet to complete it.
- Staff we spoke to showed a good level of knowledge and understanding about safeguarding. One member of staff informed us that they had a suspected safeguarding issue regarding a child around four months prior to the inspection. The dentist treating the child made a referral to social services and discovered that they were already aware of the child. Staff said that normally there would be a note in the patient record if they were subject to a safeguarding plan. If such a child missed an appointment staff said they would inform social services.
- There were two leads for child safeguarding and one lead for adult safeguarding. Staff we spoke to were aware of who the leads were.

Medicines

- We found three cylinders of nitrous oxide at Acton Health Centre that were past their expiry date. One was labelled as 'in use' and was over a year past the expiry date; one was labelled 'spare' and was four months past the expiry date. One in storage was eleven months past the expiry date. This was not a risk to patient safety and staff rectified it as soon as we informed them. However it highlighted that there was no effective system in place to check the expiry date of the nitrous oxide. Gas cylinders at other locations were within date and we saw evidence that checks were undertaken.
- We observed the safe storage of emergency medicines and reviewed a logbook, which recorded weekly checks had taken place. This was evidence of good practice for patient safety, ensuring that the emergency medicines were suitable for use in an emergency. It also meant that the risk of anyone inappropriately obtaining the medicines or of the medicines being damaged was minimised.

Environment and equipment

- There was a lack of security at Acton Health Centre. There were no lockable doors to the reception area and consulting rooms were accessible to the public. We observed the reception area being left un-staffed with the computer unlocked and the drawers containing medical records unlocked. This was a risk to patient confidentiality as people in the waiting area may have been able to gain access to personal confidential information. However we observed that staff had locked the consulting rooms when no one was in them.
- The three waiting areas we observed appeared clean. There were toys available for children. Wembley Centre for Health and Care and Grand Union Village Health Centre shared waiting areas with other community services.
- Managers informed us that a maintenance contract was in place to service equipment annually. We saw evidence that servicing of the ultrasonic cleaners and autoclave sterilisers in the decontamination rooms was up to date at all three locations we visited. The date of when the next service was due was also indicated.

Requires improvement

Are services safe?

- We saw evidence showing that daily checks of the autoclave sterilisers were completed. There were some failed daily tests for one of the autoclave sterilisers at Wembley Centre for Health and Care. Staff also told us that this steriliser often failed to work. They had called the maintenance company responsible who came to look at it but the problem was still on-going. They used the spare autoclave when that one failed the daily safety test.
- The resuscitation trolleys had all required equipment in line with guidelines from the Resuscitation Council (UK) recommendations. All equipment was within service dates and was packaged correctly. There was a logbook showing that staff checked the equipment on the trolley daily.
- We examined the x-ray rooms at all locations visited, which contained an extra-oral machine (DPT) and portable intra-oral machine and developer. We saw logbooks for all patients who had had an x-ray, using patient identifier and type of image taken and for when fixer and developer solution changed along with the step wedge test. This showed that safety checks were carried out in line with IRMER guidelines (Ionising Radiation (Medical Exposure) Regulations 2000). All equipment service dates were within one year of expiry according to the labels on machines.
- We saw documentation of up to date servicing and testing of the intra-oral x-ray machines in the treatment rooms and the portable machine. We saw documentation of weekly x-ray machine checks for exposure and hard copies of films taken. We also saw documentation that IRMER checks were completed annually and a document containing the radiation protection policy and procedures.
- Staff told us that the reverse osmosis water system (used to purify water) at Acton Health Centre had leaked around six times in the last year. Staff said that they put this on the risk register, but it was removed. The leak caused damage to one of the carpets. Staff asked for the carpet to be replaced, but the trust told them they would not pay for it.
- We observed that a resuscitation bag taken on domiciliary visits (to a community hospital and a patient's home) did not contain an oxygen cylinder. This was a potential risk to patient safety. The clinician should have been able to provide the same level of emergency care as the patient would have received at the community centre base. The member of staff informed us that their car was not insured to carry oxygen. The clinical lead and service manager were not aware that the clinician was not taking oxygen and told us that any car could carry oxygen as long as a notification label was with it. Other dentists we spoke to confirmed that they did carry oxygen on home visits.
- There was no hoist for transferring people who used wheelchairs at Wembley Centre for Health and Care. The other locations had access to a hoist and staff who used it had completed manual handling training. We observed one member of staff using a hoist safely with assistance from the patient's partner, in line with the patient's wishes.
- There were fire evacuation chairs for wheelchair users where treatment rooms were not on the ground floor.
- There was only one defibrillator on site at Acton Health Centre, which was on the ground floor. The dental treatment rooms were on the first floor and staff told us they felt that this was a risk. However they told us that they had done a test to see if they could fetch it within three minutes (guidance from the Resuscitation Council (UK) states that under ideal circumstances the defibrillator should be used within two or three minutes after collapse) and found they could. This showed that staff had addressed the potential risk to patient safety and found that the risk was minimal.
- All the locations we visited had a magnifying glass for checking that the equipment was clean. This was not a standard requirement, but demonstrated good practice of hygiene and infection prevention and control.
- Staff at all sites we visited said that ordering stock was a problem. They said that the system for ordering stock replacement had become more prolonged and inefficient since the merger. Meeting minutes from July 2015 stated that stock could take up to a month to arrive after staff had ordered it. Staff said that sometimes they received the wrong items if the person placing the final order entered the code incorrectly. They often had to get supplies from other locations.
- We saw documentation for the Control of Substances Hazardous to Health (COSHH). This showed that there were systems in place to ensure that hazardous substances were safely stored and disposed of, minimising patient safety risks.

Quality of records

- There was inconsistency in the methods staff used to record patient notes. Some clinicians wrote notes only

by hand, some recorded them on the computer using Software of Excellence (SOE), and some used a combination of the two methods. At Wembley Centre for Health and Care, staff recorded patient notes by hand because of a lack of software and equipment. In other locations, staff told us it was down to the preference of clinicians. Staff informed us that if they put notes on the computer, they would indicate that in the paper record (by writing "see SOE"). If there was something of significance they would also write it up in the paper notes. This ensured that important patient information was readily available.

- The service carried out a record keeping audit in 2014 and another was in progress for 2015. The audit results we saw highlighted a need to improve how staff recorded patients' next of kin/main carer and GP details. We saw that 26 out of 67 sets of notes that should have had learning disability status recorded did not. Thirty-one sets of notes for patients with a learning disability that should have had a 'health passport' (a document containing important health information for people with a learning disability) did not. Twenty-three out of the 60 patient notes audited in Ealing had not recorded the potential risks following a procedure on consent forms. We saw the service's action plan in response to the audit. However, it did not include any actions to address the issue of recording risks following procedure on consent forms, missing learning disability status, or missing GP details.
- Managers told us they fed back the audit results to staff and planned to review the 2015 results to see if improvements had been made.
- We looked at nine sets of patient notes at Wembley. All had a signed consent form where required, except one. The patient had had treatment that required a written consent form but there was not one in the records. We asked the dentist who treated the patient and they did not know where the form was but were certain that the patient had given verbal consent. The patient was living with mental health problems but the dentist was certain that the patient had capacity for consent. We were satisfied that the dentist understood capacity for consent.
- Five sets of the notes we viewed at Wembley were for children. They contained an internal summary sheet at the front of the file, but all were missing the name of the parent/guardian. We did not feel that this was a risk because the contact details of the parent or guardian were elsewhere within the notes. However, the 2014 record keeping audit results identified this as an issue, so our findings indicated that staff did not follow through with the action points from the audit.
- We looked at 11 sets of patient notes at Grand Union Village Health Centre. All had dental charts completed. We saw completed consent forms and treatment plans in some notes. One set of notes was for a patient who had a treatment plan completed by the first dentist they saw. A second dentist then treated them. The second dentist did not agree with the original treatment plan and therefore did not follow it. However, there was no new treatment plan or consent form in the patient records.
- One set of notes showed that the patient was taking an antipsychotic medicine, which was a treatment for schizophrenia and symptoms of bipolar disorder. However, there was no record of illness in the medical history section of the notes. This is a potential risk to patient safety as if a member of staff who did not know the patient treated them they may not understand or be aware of any considerations that they might need to take into account with regard to their condition.
- Hand written notes were mostly legible. We saw one set of notes out of the 11 we examined at Grand Union Village Health Centre where the hand written notes were hard to read.

Cleanliness, infection control and hygiene

- We observed staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care and treatment. Suitable arrangements were in place for the handling, storage and disposal of clinical waste, including sharps. We observed good hand washing practice and saw completed monthly hand washing audits.
- The service used a system of local decontamination at all sites for the processing of contaminated instruments used during treatment. The systems in place ensured that the service was meeting HTM 01 05 (guidelines for decontamination and infection control in primary dental care) requirements for infection control.
- Staff were able to demonstrate and explain the procedures for the decontamination of dental equipment and for the transfer, processing and storage of instruments. We observed equipment being sterilised. Staff bagged the instruments after they were sterilised and labelled the bags with the date of expiry.

Requires improvement

Are services safe?

- Treatment rooms all appeared clean. They contained Adult Basic Life Support instructions on the walls, guidelines for anaphylaxis management, waste disposal guidelines, and checklists including routine start of day check, post patient treatment check, end of day check, and cleaning checks. Prescription pads were kept locked away with the logbook. Instruments were kept in drawers with the correct packaging. All equipment was serviced and in date.
- We reviewed a sample of five bagged instruments at Wembley Centre for Health and Care and seven at Grand Union Village Health Centre. We found that staff had stamped them all with expiry dates, which were within date. This meant that the service was following Department of Health guidelines for decontamination.
- The trust cross-infection team carried out audits every six months and had set up annual cross-infection training.
- We observed that staff took a pre-stocked bag on domiciliary visits with the required sterilised instruments. After use staff bagged the instruments and placed them in a lockable container. They then returned them to the service location to be sterilised.
- The trust infection prevention and control team carried out an infection prevention audit at Wembley Centre for Health and Care in May 2015 and at Grand Union Village Health Centre and Acton Health Centre in September 2015. The team used the Infection Prevention Society audit tool which assessed compliance against HTM 01-05. The audit covered: prevention of blood borne virus exposure, decontamination, environmental design and cleaning, hand hygiene, management of dental medical devices, personal protection equipment and waste disposal. We saw documentation showing 99% compliance for all three locations, which meant the level of risk was very low.
- We saw an autoclave logbook, a washer disinfection logbook and a decontamination protocol for the service. This demonstrated that daily, weekly, monthly, quarterly, six-monthly and annual checks were carried out effectively, in line with guidance.
- At Acton Health Centre there were covers for computer keyboards. These were easy to wipe clean and were an example of good cleanliness and hygiene practice.

Mandatory training

- We saw records showing that some dentists and dental nurses had not completed all mandatory training. Six out of 24 dentists and seven out of 39 dental nurses did not have up to date basic life support training. This was a potential risk to patient safety.
- Mandatory training records provided by the trust showed that six out of 24 dentists and seven out of 39 dental nurses did not have up to date basic life support training. This was a potential risk to patient safety. Following the inspection, the trust advised the CQC that all dentists and dental nurses had attended the London Deanery accredited external one day course provided by e wisdom “First aid, Medical Emergencies and Resuscitation” and all were up to date on the visit.
- Staff used the trust’s online training system ELMS (E-Learning Management System) to log training and to complete online training courses. The service manager informed us that they can use ELMS to monitor which staff members had outstanding mandatory training. They told us that the reason some training was outstanding was due to the trust cancelling and rescheduling courses. They were booking some courses on dates in 2016 for training that had expired. The service manager told us that they had informed the trust’s learning and development team of the issue.
- Staff told us that they were happy with the ELMS online learning system and that it was an improvement since the trust merger.

Assessing and responding to patient risk

- We saw information in the treatment rooms detailing actions to take in the case of an emergency. This included choking, hyperventilation, hypoglycaemia, epileptic seizures and cardiac emergencies. We also saw a sharps injury procedure.
- We saw protocols for medical emergencies and risk assessments for domiciliary visits.
- The service had a form for risk assessments for domiciliary visits. We observed a dentist completing this form on the two domiciliary visits. Other dentists told us that they used this form when making domiciliary visits. They put the form in patient notes for future use.

Requires improvement

Are services safe?

- We saw an inhalation sedation protocol, which included a patient information sheet and consent forms. However, we found that staff we spoke to were not aware of the protocol as they told us that there was no protocol or checklist.

Staffing levels and caseload

- Dental nurses regularly worked across the different locations to cover nursing staff shortages. If there were dental nurses on administrative duties at one site and another site was short for clinical duties they were moved accordingly. The service manager told us that they tried to keep dental nurses at their primary site when possible. They regularly used bank staff and at one clinic there was a bank dental nurse covering maternity leave. The service did not use many agency staff. At Grand Union Village Health Centre there were two agency staff used regularly.
- Staff told us that having cover from bank or other staff sometimes made things more difficult because, for example, they did not know where things were kept.
- Staff said that dental nurses regularly had to cover administrative duties. They also had to perform decontamination duties which a less qualified nurse could have done. They felt that they were often having to do other people's work and therefore did not have enough time for their own. One example given was that a dentist had to clean a treatment room, as the dental nurse was busy decontaminating dental instruments.
- Dentists at Grand Union Village Health Centre often had to book appointments when there was no administrator. They did not want to keep patients waiting so would stay after the end of their shift to complete their own administration work. Staff said this was regularly a problem in the afternoon as there was no administrator working in the afternoons. They told us that this had been a problem for a long time. They had raised it in recent three-monthly Ealing staff meetings, but the service manager had told them there was no money available to employ more staff.
- Staff at Grand Union Village Health Centre told us that they had to regularly cancel clinics due to staff shortages and sickness absence. The most recent was the week prior to inspection. They also told us that they had suggested getting a different staff skill mix to make the service more efficient (for example band two nurses to perform decontamination duties instead of more highly qualified nurses) but managers did not agree with their ideas.
- We did not see any evidence of a risk assessment relating to staff shortages. This meant that the service had not fully assessed the potential impact that staff shortages could have on patient care and safety.
- The dental nurse team lead told us that they tried to go to each site at least once a week and would base themselves where staff most needed them. This meant that it could be difficult to provide appropriate support and cover at all locations. They had suggested to management that a laptop would help them to work more efficiently by accessing their work from any site but they had not yet heard what the outcome was.
- Dentists had no more than two domiciliary visits in a morning or an afternoon. Dentists were always accompanied by a by a dental nurse on visits. Parking on domiciliary visits was often a problem and it could take them a long time to find a suitable space. This potentially limited the number of patients the dentists could see.
- Staff told us that they cancelled clinics if a dentist was off due to illness as there was no one to cover. They told us that this did not happen often and that they could usually rebook patients quite soon for core services. If it was for treatment then the patient would normally be booked in again within a week.

Managing anticipated risks

- The service had contact details for equipment failure and waste management. We also saw a document entitled "Guidelines for the Management of Medical Emergencies in Community Dental Clinics". This included details on what to do in medical emergencies and where emergency equipment and medicines were stored.

Good

Are services effective?

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

Summary

We rated effective as good because:

Staff were following national and local guidelines to deliver effective care and treatment.

Staff were well trained had the knowledge, skills and competence to carry out their roles and responsibilities effectively and some were undertaking courses to further their learning and development.

Patients who required treatment under general anaesthetic had to be referred to external hospitals because there was no suitable service available within the trust. This often involved long waiting times and delays to treatment which could be detrimental to the patient's oral health. For example some patients missed the optimum time for premolar tooth extraction.

Systems to manage patient records were cumbersome and uncoordinated. Some records were recorded using an electronic system whilst some were hand written. This was partly due to limited availability of software and equipment and partly due to staff preference and insufficient training. At one location all appointments and records were paper based.

There was no set protocol for recording consent within the service and dentists differed in which treatments they sought written consent for. However, we did not feel that this posed a risk to patient safety. We observed dentists obtaining appropriate implied and/or verbal consent.

Evidence based care and treatment

- We saw the effective use of guidelines from the Department of Health publication, Delivering Better Oral Health Toolkit when observing dentists treating patients. The most recent version of this document was available for staff to refer to.
- We saw a protocol containing National Institute for health and Care Excellence (NICE) guidelines for wisdom tooth extraction, recall interval, antibiotic prophylaxis guidelines. This showed that the service provided evidence-based care.
- Care and treatment under inhalation sedation was undertaken in line with guidelines from the Standards for Conscious Sedation in the Provision of Dental Care (a joint publication by the Royal College of Surgeons and Royal College of Anaesthetists).

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- There was inconsistent use and availability of software and IT equipment at the service locations. The service at Wembley Centre for Health and Care did not have any access to Software of Excellence (SOE), the electronic system for appointment bookings and records. Therefore they stored all records and appointment bookings in paper format. Other locations used a combination of paper and electronic notes. This was due in part to staff preferences. Some preferred to write by hand as they felt it was easier than using SOE. Staff also told us that this preference is due to a lack of available training on SOE. Staff said they had raised this with management but had not heard anything back.
- A dentist informed us that they had access to the same SOE system at two of the locations and that this made their work more efficient. It also made it easier to transfer patients and their records between those locations. They felt that it would be beneficial to the service and improve the quality of patient care if they had access to computers and SOE at all locations.
- The service manager and clinical lead told us that the lack of sufficient IT software and equipment meant that they could not effectively monitor and analyse dentists' activity. They had requested software and equipment from the trust who told them that there were financial issues causing a delay. Senior managers also told them that the trust IT department would need to provide support for the software so that they did not have to pay a subscription for support from the supplier. This was also adding to the delay.
- Staff told us that if they had sufficient IT systems and equipment in place it would free up more of their time.

They would then be able to see more patients and spend more time with them. Staff told us they regularly stayed past their finishing time to catch up with administrative work.

- There was no access to the trust intranet at Heart of Hounslow Centre for Health. The dental nurse team lead was unable to access anything that they had saved on their computer at Hounslow from other locations. Staff at the other locations could access the trust intranet and found this useful in keeping up to date and accessing information.
- Staff at Grand Union Village Health Centre had problems accessing a program used for reviewing digital images because the trust had only installed it on one computer. The Hounslow site had a DPT machine (a dental panoramic tomography machine used for imaging) but the software was too big for the server and therefore staff could not use it.

Patient outcomes

- Staff felt that they could not easily monitor patient outcomes for those patients they referred on to tertiary care outside the trust. They felt that this could be improved by having a general anaesthetic service within the trust, which would improve continuity of care for patients. We did not see any systems in place for monitoring patient outcomes within the service.

Competent staff

- All dental nurses except one were qualified dental nurses. Some dental nurses had also undertaken additional extended duties qualifications in areas such as dental radiography and dental sedation nursing.
- One dentist was studying for an MSc in Paediatric Dentistry and this was partly funded by the trust.
- Administrative staff told us that they felt supported and had opportunities for learning such as through the ELMS on line learning system.
- One dentist had completed a self-funded British Sign Language course in Makaton in order to help their understanding of people with learning disabilities. Makaton is a language programme using signs and symbols to help people to communicate. It was designed to support spoken language and the signs and symbols are used with speech, in spoken word order.
- Two dentists in the service were studying for a diploma in special care dentistry. The trust was supporting this. One dentist was studying for a diploma in paediatric dentistry and clinical lead was trying to get funding from the trust to support this.
- Staff told us that they had annual appraisals. They said that the focus was more on their wellbeing rather than development needs and career progression. They told us that in terms of career progression, there is no sense of a learning or development pathway. They said that in appraisals managers told them that there is no money for additional courses and training.
- Staff said that they could apply to do external courses but that the time it took to get approval from the service manager meant that the course often became booked up.
- Staff informed us that new jobs were being down banded – if a band five nurse left, they would recruit a band four nurse in their place. This had an impact on staff motivation as it meant that existing band four staff could not apply for the new role to progress. They felt that staff turnover had increased as a result.

Multi-disciplinary working and coordinated care pathways

- The same dentist usually saw patients throughout their care in the community dental service. This ensured a good continuity of care. Staff felt that this was especially important for patients with special needs. An exception to this would be in the case of an emergency.
- Staff at Acton Health Centre felt that they had good communications with other community services that were in the same building due to the layout of the building. They found it easy to interact and make links with other teams such as health visitors and school nurses.
- We found limited evidence of the service working collaboratively with the local oral health promotion teams. Staff at Acton Health Centre told us that the school nurse and health visitors worked with the oral health promotion team. One dentist had attended an oral health promotion workshop. The Oral Health Promotion Team had given a presentation at a recent staff meeting at Acton Health Centre.

Good

Are services effective?

Referral, transfer, discharge and transition

- The service followed NICE guidelines for recalling patients for follow up appointments. We saw evidence of this in clinics and in patient records. Patients were recalled according to their individual needs.
- Staff felt that not being able to refer patients for treatment under general anaesthetic within the trust was a problem for patients. They told us that patients complain about being referred to hospitals that are far away. There used to be a specialist dentist at Northwick Park Hospital where the community dentists could refer people to but they left the service over two years ago and the trust had not replaced them.
- Staff told us that external hospitals often rejected referrals because they did not think they would be able to meet the special needs of patients. Staff told us that they had to write a note on the front of the referral form explaining that the referral was for an extraction only so that the hospital would not reject it.
- We saw meeting minutes from a staff meeting in April 2015 stating that a dentist referred a patient to Northwick Park Hospital for treatment under general anaesthetic. The hospital rejected the referral because the patient was an adult with special needs. They stated that they no longer had a special needs department and were not funded for special needs referrals under general anaesthetic.
- Dentists said they had developed contacts at other hospitals, such as the Eastman Dental Hospital, and had good communication with them, which ensured smooth discharge and transitional arrangements for on-going care and support.
- When the dentists referred patients on to Northwick Park Hospital or Ealing Hospital, i.e. within the trust, the hospital treated the referral as an external referral. This meant that there was no improvement in efficiency by the process being within the trust. Staff did not often refer to Ealing Hospital as they did not take their own radiographs and did not have a specialist paediatric consultant for treating children in orthodontics.
- The delays caused in referrals for extractions sometimes resulted in problems for patients. Some patients had missed their window of optimum age for wisdom tooth extraction as a result of the waiting time from referral to appointment. The window of optimum age is when the teeth are still growing and can fill the gap left by a premolar tooth being removed.
- A member of staff we spoke to at a secondary care hospital during a domiciliary visit told us that they were happy with the referral process in terms of referring their patient to the community dental service.
- We saw a protocol for rebooking patients who did not attend their appointment and for returning to the referring clinician. Staff we spoke with were aware of this protocol.
- We saw guidelines for referral into the community dental service and criteria for when dentists should refer patients on to a specialist. For example, patients with aggressive periodontitis (an inflammation of the tissue around the teeth, often causing shrinkage of the gums and loosening of the teeth).

Access to information

- Patient records were stored in lockable drawers at all locations we visited. Staff said that they did not have any problems accessing information.
- Some dentists used electronic records instead of paper notes but would mark “see SOE” on the paper notes. They also wrote anything of significance in the paper notes.
- We observed staff taking patient notes with them on domiciliary visits. This meant that they had timely access to information. Staff put the notes securely in a zipped bag during transportation.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just ‘Consent’ for CYP core service)

- There was no set protocol for recording consent. However, we did not feel that this posed a risk to patient safety. We felt that there were adequate processes in place for gaining consent even if the consent was not recorded.
- There was inconsistency in the use of consent forms. Some staff told us they used consent forms only for invasive treatment. Others told us they did not use a consent form for a filling (which some considered to be invasive treatment). Some dentists said that they only obtained written consent when there would be an impairment of consciousness.
- We observed dentists obtaining appropriate verbal and implied consent on domiciliary visits and in treatment room consultations.
- Staff we spoke with displayed a good understanding of capacity for consent. They were aware of best interest

assessments and knew which consent forms to use. They used separate consent forms for patients who had someone else consenting on their behalf. We observed staff on a domiciliary visit checking with a doctor that the patient they were assessing had capacity for consent. We observed clinicians gaining verbal consent from patients in examinations.

- Staff told us that patients signed a treatment plan and that the dentist ensured they understood what they were consenting to. But we did not see consistent use of treatment plans when we reviewed patient notes. Some notes contained treatment plans, but some did not, which demonstrated that there was no consistency in their use. However, we did not consider this to be damaging to patient care because, in the consultations we observed, patients were aware of what treatment they would be having.
- One patient had a treatment plan made by a dentist other than the one carrying out the treatment. The dentist carrying out the treatment did not agree with the original treatment plan and did not follow it. They did not complete a new treatment plan or consent form. The dentist informed us that this rarely happened and that usually one dentist completed the treatment plan and carried out the treatment. The dentist discussed this with the patient's parent and explained the reasons for the change.
- Some dentists had completed Mental Capacity Act training. It was not part of the mandatory training programme.
- We saw the service's protocol on how to assess and apply the Mental Capacity Act. We saw that the service had the trust-wide form for capacity assessment.

Good

Are services caring?

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

Summary

We rated caring as **good** because:

We found staff to be caring and passionate about their work. They were hard working, committed and were proud of the service they provided. People were treated with respect and kindness during interactions with staff. They were communicated with in a way that they could understand. Patients were supported in managing their own oral health and care when they could.

Patients, parents, partners and carers we spoke to said they were happy with the service. They felt well-informed and were involved in decisions. One patient's parent told us that they thought the service was excellent, and responsive to their needs. They had been able to rearrange an appointment when it was difficult to fit it around their work, and also said it was helpful that they had received a phone call to remind them of the appointment the day before.

Compassionate care

- Staff we spoke to were passionate about providing good patient care and told us they enjoyed helping people. They told us that patients are the centre of focus in the service.
- We observed appropriate introductions and interactions between staff and patients, on domiciliary visits and at the three service locations we visited.
- We observed staff ensuring that patients were comfortable with their environment. Staff told us that they may spend the first appointment with a new patient acclimatising them if they were especially anxious or had complex needs.
- Staff said that they were proud of their work, especially when patients were happy and had a positive experience. They said they get a lot of positive feedback from patients.
- Most patients, parents, partners and carers we spoke to were happy with the service. They felt informed and involved in the treatment plan. Where we observed a complication during the treatment of a child, the dentist explained the situation to the parent.
- We observed a dentist examining an adult patient who had physical disabilities. When they spoke to the patient they changed the tone of their voice, spoke slowly and simplified their words. We observed that the patient was fully able to understand what was being said and therefore this may not have been necessary. This was an example of the absence of soft-skills. However, the patient and carer seemed satisfied with the dentist.
- Many staff told us it that they would recommend the service to a family member or friends.

Understanding and involvement of patients and those close to them

- We observed staff informing patients of what they were doing during the consultation. Where the patient was a child they explained things in a way the child could understand and kept the parent informed. In one consultation with a child there were some complications but the dentist handled the situation well and gave a thorough explanation. We also observed a dentist experience complications while treating an adult patient. The dentist kept the patient informed and explained what was happening and the patient appeared to be comfortable and satisfied with the explanation.
- The clinical lead informed us that the service was an early adopter of the NHS Friends and Family Test and had been using it since October 2014. Staff were encouraged to hand out the Friends and Family Test form. The clinical lead reviewed the comments and informed us that they had not had to take any action in response to comments as they had all been positive. The service scored well in the test and achieved an average of 98% across all locations from May to August 2015. This meant that 98% of respondents said they would recommend the service to a friend or relative. This was better than the national average of 95% for community services in England in September 2015.
- Staff gave patients information leaflets for self-care including preventative advice and aftercare. For aftercare the service used information from the Delivering Better Oral Health Toolkit in their patient information leaflet. Dentists also talked through aftercare and preventative methods with the patients and/or their parent, guardian or carer.

Good

Are services caring?

Emotional support

- We spoke with staff responsible for providing care and treatment for children and adults with special needs who demonstrated their compassion and understanding of the level of emotional support required for both patients and their relatives or representatives.
- We observed staff being supportive and caring with a nervous patient. We also observed staff examining a patient with autism. They were calm and caring in their approach and were considerate to the patient needs.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

Patients did not always have access to care and treatment needed in a timely manner due to waiting times for specialist services (endodontics and periodontics). The service did not have an effective general anaesthetic referral pathway because there was no appropriate general anaesthetic service within the trust. There were no leaflets available in any language other than English.

Planning and delivering services which meet people's needs

- Staff told us and we observed that there were no leaflets available in other languages at any of the locations we visited. There was a poster at Wembley Centre for Health and Care that gave information about interpreting services in different languages.
- The organisation of appointments was responsive to the needs of patients. Dentists made domiciliary visits where the needs of the patients necessitated this. Visits included to patients' homes as well as to secondary care locations. These visits were no longer included in the service level agreement but the dentists continued them nonetheless. A member of staff at the secondary care location we visited during the domiciliary visit told us that they felt it was of great benefit to the patient for the dentists to make the visit rather than the patient having to go to the service. They told us that other community services do not offer this.
- Dentists had no more than two domiciliary visits in a morning or an afternoon. For specialist services (endodontist and periodontist appointments) the appointments were longer than regular ones. Staff mainly felt that they had enough time with patients. We saw examples of dentists giving patients with learning difficulties and/or special needs time to acclimatise to the environment when they required this.
- The service booked interpreters for patients who required one. Their referral letter would normally state if an interpreter was required. Staff said that occasionally patients would come with a family member or friend to interpret. If a patient who needed an interpreter came to an appointment and one had not been booked, they would rebook them for another day.
- The service had information leaflets available for patients including denture care, relining dentures, dry mouth management, and gum disease management. At Acton Health Centre there was a display about how to swap food and drink containing high levels of sugar for more healthy choices. This was a simple to understand, child-friendly display.

Equality and diversity

- The service did not have patient information leaflets available in other languages. They had an interpreting service for people who did not speak English.
- The locations we visited were fully accessible for people with a physical disability or who required the use of a wheelchair. There were hoists available at all locations except Wembley Centre for Health and Care.

Meeting the needs of people in vulnerable circumstances

- Most staff did not have soft skills training to help enable them to support people with physical or learning disabilities (relating to behavioural and emotional needs). There was a learning disabilities champion course available which one staff member had signed up to attend. The clinical lead had completed this course. Staff told us that they learnt on the job and that they shared and acquired experience and skills across the team. They felt they would benefit from training in learning disabilities and had raised this with the service manager.
- Staff told us that dementia training was part of the mandatory online training.
- Staff assessed patients' level of anxiety, ability or willingness to undergo treatment, as well as their level of cooperation. Where appropriate they would refer the patient for a general anaesthetic at a tertiary hospital. For example if a three year old child required an extraction of a tooth they would refer them for general anaesthetic, but if a seven year old required one and was not anxious and had a good level of cooperation then they might treat them under local anaesthetic.

Requires improvement

Are services responsive to people's needs?

Access to the right care at the right time

- There was a long waiting time for specialist services (endodontics and periodontics) - from April to October 2015 the average waiting time was 12-18 months. The waiting list time for the specialist paediatric dentist (who worked one half day per week at Grand Union Village Health Centre) was approximately 6 months.
- The waiting time (from referral to first appointment) for core service appointments was within the 18 week requirement at all locations from April to October 2015.
- The service manager and clinical lead informed us that they had raised the issue of long waiting times with the trust, but were told that there was not sufficient funding for more staff. They also told us that it can be difficult to find appropriately trained people, as there is a national shortage of specialist dentists.
- The clinical lead triaged patients on the waiting list and allocated them to a clinician. The clinician then prioritised them according to their needs.
- Staff told us that they thought the service would benefit from a specialist consultant who could administer and treat under general anaesthetic. This would reduce the amount of time patients had to wait when they required further treatment under general anaesthetic at a tertiary hospital.
- An out of hours emergency helpline was available and the number for this was on the leaflet given to patients after treatment. The service had been given a new after-care leaflet by the trust, but this did not have the out of hours emergency telephone number, so they continued to use the old one. This telephone number was also on the voicemail message outside of opening hours and the service displayed it on posters in the waiting areas.

Learning from complaints and concerns

- Staff told us that patients could make a formal complaint by writing to the trust Patient Advice and Liaison Service (PALS). The clinical lead investigated any complaints made about the service. The clinical lead told us there were no formal complaints made about the service in the last 12 months. Staff said that they would inform PALS if a patient made a complaint directly to the service.
- Staff said that they did not hear if a complaint was made to PALS unless it involved them.
- There were leaflets in the waiting areas with information for patients on how to make a complaint.

Requires improvement

Are services well-led?

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

Summary

We rated the service as requires improvement for well-led because:

Staff were not aware of the trust vision and strategy. We did not see evidence of a vision or strategy at a local level. The main aim seemed to be to maintain the current service within the financial constraints. Staff felt that the service was stand-alone and remote, with little involvement with the trust. Trust-level management was not visible. Managers within the service were based at a location separate to where the services were located. Their time was split between there and the service locations. Some staff felt that the absence of managers was an issue at some locations.

Service vision and strategy

- The clinical lead and service manager told us that the trust had not communicated the trust vision to the community dental service. They told us that they were passionate about maintaining, promoting and developing community dental services. They had anxieties about the future and were worried about resources. They felt there had been a disinvestment in the service.
- Staff told us that they had a strong sense of standing alone and felt disconnected from the trust.
- The trust's values were not on display in the clinics we visited. Staff we spoke to were not aware of the vision, values and direction of the trust.

Governance, risk management and quality measurement

- The service had a clinical governance lead.
- There was nothing on the trust risk register relating to community dental services. The clinical lead told us that they thought the IT problems that the service had should be on the register and that they had informed the trust. The main problem was that IT software for booking and records was not available at all sites.
- We found that the service did not have robust arrangements for identifying, recording and managing risks, issues and mitigating actions. We saw a document containing a policy and guidelines for the risk register however issues such as the security risk at Acton Health Centre were not on the risk register.
- Managers were not aware of whether the board discussed issues concerning community dental services at board meetings or not.
- Dentists attended a quarterly clinical effectiveness meeting on behalf of each site. They discussed clinical governance, improvements and governance issues in these meetings.
- Staff told us that the service had completed an audit on the Delivering Better Oral Health Toolkit.We saw documents with the audit results and an action plan detailing areas for improvement. We saw evidence of completed handwashing audits and a record keeping audit completed in 2015.

Leadership of this service

- Senior managers were based at a separate location from those where the services were located. The clinical lead attended the service locations on an ad hoc basis. The service manager usually attended each location weekly. Staff told us that they were able to call the clinical lead if they had any queries. They told us the clinical lead was approachable and always willing to help them.
- Some staff felt that the absence of mangers at some locations was an issue.
- The majority of staff we spoke to said they felt supported by their line manager.
- Staff were aware of who was their director on the board. Managers told us they had raised issues with divisional managers and board members but that they do not hear any feedback or see any action as a result. Staff said that no one from the board had been to any of the sites to look round or speak to them.

Culture within this service

- Staff told us that they did not notice any significant changes when the trust was created in 2014. Some felt that they had seen positive changes – that things had

Requires improvement

Are services well-led?

become streamlined and more organised. They gave the example of weekly newsletters and e-bulletins that came from the trust. They felt that these made them feel included and kept them informed.

- Some staff said they felt that the trust was quite remote from them.
- Staff informed us that team morale was low, and that this was due to understaffing. Some staff felt that the service had become target-driven and that not enough consideration was given to the needs of vulnerable patients.
- Staff we spoke to felt that they were well-supported by their peers.

Public engagement

- Managers told us that they encouraged staff to give out the Friends and Family Test forms to get feedback from patients and their relatives, guardians or carers. The clinical lead reviewed comments from the feedback. We observed staff giving out the forms and saw evidence of discussion of the forms in meeting minutes.

Staff engagement

- Staff told us that the service held tri-borough meetings twice a year and invited speakers to give a presentation. All staff were invited to attend. Staff told us that they did not feel comfortable raising concerns with managers at this meeting.
- Grand Union Village Health Centre and Acton Health Centre held quarterly staff meetings where concerns could be raised. At Wembley Centre for Health and Care staff said they did not attend formal meetings but had ad hoc lunch time meetings.
- The service was in the process of conducting a staff survey during the inspection. Staff we spoke to did not recall completing one before this, they thought the last one was around three years ago.
- Staff we spoke to said that there was not much opportunity to feedback about their concerns or ideas. They felt that they could tell their managers but that they usually did not hear any feedback.

Innovation, improvement and sustainability

- The clinical lead told us that it was difficult to improve services due to the lack of money. However, staff were receptive to discussing potential improvements and taking things on board. For example they embraced the recommendations made in the Delivering Better Oral Health Toolkit and conducted an audit on the use of the toolkit.
- Staff told us that increasing staffing would significantly improve the service and reduce risks. They had raised this verbally with management, but were told there was not enough funding.
- The clinical lead informed us that a clinician recently introduced an email clinical forum as an opportunity to share learning. The clinical lead gave us the example of a dental x ray result she had shared in the forum.
- One member of staff informed us that they had suggested a resolution to the issue with ordering stock but that managers had dismissed this. This was for one site to order and receive delivery of all stock to improve efficiency and save money.
- Managers told us that the service plans to get SOE installed across all sites.
- A number of the dentists had additional post graduate degrees and diplomas. This enabled the service to provide increasingly complex care to an increasingly complex and diverse patient base.