Whitecross Dental Care Limited

Oswestry Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations

Background

Oswestry Dental Centre, part of a national corporate dental body, is a mixed dental practice providing mainly NHS and some private treatment for both adults and children. The practice is situated in a converted commercial property. The practice had four dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. The dental treatment rooms are all situated on the ground floor.

The practice is open 9:00am to 5:30pm Monday to Friday. The practice has three dentists who are supported by four dental nurses and two receptionists.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from patients. These provided a completely positive view of the services the practice provides. Patients commented that the quality of care was very good and staff were helpful and understanding.

Summary of findings

Our key findings were:

- The practice was in a transitional phase following a succession of several practice managers in recent times.
- We found the new practice manager to be hard working, committed and determined to provide effective managerial leadership to the practice.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead with effective safeguarding processes in place for safeguarding adults and children living in vulnerable circumstances.
- The service was aware of the needs of the local population and took those these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- A process was in place to report incidents and for shared learning.
- On the day of our visit there were enough staff to support the dentists during patient treatment. However some staff did reveal that at times the practice was short staffed for both dental nurses and dentists with staff borrowed from a sister to practice to cover shortfalls.
- Staff recruitment files were well organised and complete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Information from eight completed Care Quality Commission (CQC) comment cards this gave us a positive picture of a friendly, professional service.
- The practice had a rolling programme of clinical and non-clinical audit in place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had robust arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

We collected eight completed CQC patient comment cards on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services. The practice had ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

The practice was in a transitional phase from a leadership point of view. The practice had suffered from a succession of practice managers which had affected the morale of the practice. However, we found that the new practice manager was determined to improve the situation and had started to strengthen and improve he governance systems of the practice. The practice manager and other staff had an open approach to their work and shared a commitment to provide a good service. The practice had clinical governance and risk management structures in place. Staff told us that they could raise concerns with the practice manager and they would do their best to act on problems and concerns raised.

Oswestry Dental Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 11 March 2016 and was led by a CQC inspector who had access to remote advice from a dental specialist advisor Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members and proof of registration with their professional bodies.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the practice manager, dentists, reception staff and reviewed policies, procedures and other documents. We reviewed eight comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an adverse incident reporting policy and standard reporting forms for staff to complete when something went wrong. The policy contained clear information to support staff to understand the wide range of topics that could be considered to be an adverse incident. The practice also had an appropriate accident record book which was used correctly to protect the privacy of individuals filling in the forms. This enabled the company to analyse the incidents and share any learning with the rest of the practices in the group through the company newsletter known as the 'buzz'. The practice received national patient safety alerts from company head office in the form of a regular bulletin that described the learning points arising from these alerts. The practice manager reported that there had been no incidents reported in the previous twelve months.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse/receptionist about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. A single use system was used to deliver local anaesthetics to patients. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. There had been no needle stick injuries in the previous twelve months.

We asked how the practice treated the use of instruments during root canal treatment. The dentists we spoke with explained that these instruments were single use only. They explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

The practice had a nominated individual, the practice manager, who acted as the practice safeguarding lead. This individual acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse. Training records showed that all staff had received safeguarding training for both vulnerable adults and children within the past 12 months. Information was available that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice manager described a safeguarding issue that had arisen during their tenure (six months) as practice manager. We found that the issue had been dealt appropriately and proportionately and in accordance with the practice policy.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff received annual training in how to use this. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had two oxygen cylinders along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen were all in date and stored in central locations known to all staff.

The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet that enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. The last training session was in November 2015. As part of maintaining competency, the practice also undertook simulated medical emergency scenario training on a quarterly basis. We saw the evaluation of the of previous scenario training in November 2015. We found that the post evaluation questionnaires filled in by staff demonstrated that staff found the session valuable and an enjoyable learning experience.

Are services safe?

Staff recruitment

All of the dentists and dental nurses where appropriate had current registration with the General Dental Council, the dental registrant's regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, we found that a new starter, who attended on the day of our visit, had a recruitment pack that demonstrated proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references. We looked at examples of other staff recruitment files; these were also well maintained and complete. The records confirmed that the individuals had been recruited in accordance with the practice's recruitment policy. Staff recruitment records were stored securely. We saw that all staff had received a criminal records checkthrough the Disclosure and Baring Service (DBS).

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file detailed how materials used in the provision of dental treatment were to be handled to prevent harm to staff and patients alike. Other assessments included radiation, fire safety, health and safety and water quality risk assessments. The fire safety folder was well maintained and complete, this contained a fire risk assessment and records showing that the fire extinguishers had been maintained regularly and staff had undergone appropriate fire safety training. The practice had a detailed business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice manager had delegated the responsibility for infection control procedures to the practices' lead dental nurse. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. It was observed that an audit of infection control processes carried out in February 2016 confirmed compliance with HTM 01 05 guidelines.

It was noted that the four dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including wall mounted liquid soap and paper towel dispensers in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

We found the drawers of treatment rooms well-stocked, clean, organised and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

We asked the lead dental nurse to describe to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). They described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in 2014 with a review date of 2016. The recommended procedures contained in the report were carried out and logged appropriately. This included regular testing of the water temperatures of the various taps in the building. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. This room was organised, clean and tidy and clutter free. Dedicated hand washing facilities were available in this room. The dental nurse

Are services safe?

demonstrated the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing and ultrasonic cleaning bath for the initial cleaning process, following inspection they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The dental nurse also demonstrated that systems were in place to ensure that the autoclaves and ultrasonic cleaning bath used in the decontamination process were working effectively. It was observed that the data log books used to record the essential daily validation checks of the sterilisation cycles and routine validation tests of the ultrasonic cleaning bath were always complete and up to date.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice and was stored in a separate locked storage room prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated clinical waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the two autoclaves had been serviced and calibrated in March 2015. The practices' X-ray machines had been serviced and calibrated in August 2015 in accordance with national guidelines and portable appliance testing had been carried out in March 2015. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. NHS prescription pads were stored in a safe overnight to prevent theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. At this location, each individual dentist acted as the Radiation Protection Supervisor for their dental treatment room. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A copy of the radiological audits for each dentist carried out in February 2016 demonstrated that dental X-rays were of a good standard of quality in terms of positioning and processing. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke to three dentists who described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A review of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The waiting room and reception area at the practice contained leaflets that explained the services offered at the practice. This included information about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. The company web site also provided information and advice to patients on how to maintain healthy teeth and gums. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. All three dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or appropriate high concentration fluoride tooth paste to keep their teeth in a healthy condition. They also placed special plastic coatings (fissure sealants) on the biting surfaces of adult back teeth in children who were particularly vulnerable to dental decay. The practice had a range of dental health products patients could purchase which were suitable for both adults and children. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients.

Staffing

On the day of our visit there were enough staff to support the dentists during patient treatment. However, some staff did reveal that at times the practice was short staffed for both dental nurses and dentists. The practice manager addressed this issue as best as they could in the short term by borrowing staff from a sister to practice to cover shortfalls. However, a permanent solution to the problem needed to be addressed by the company as a whole. All of the dental nurses supporting the dentists were qualified dental nurses apart from one trainee dental nurse who was undergoing a period of training. The practice manager told us that the company ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to support staff development including internal company training through the academy programme and staff meetings as well as attendance at external courses and conferences. The company provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and other specific dental topics. This was evidenced through observing a sample of recruitment files.

Working with other services

The practice manager explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the

Are services effective?

(for example, treatment is effective)

treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers. This ensured that patients were seen by the right person at the right time. We saw two examples of referrals that demonstrated that the referral criteria for orthodontics and oral surgery were met.

Consent to care and treatment

We spoke to three dentists on duty on the day of our visit; they all had a clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

The dentists we spoke with explained how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. They explained if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms that protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable metal cabinets behind the reception area. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. On the day of our visit we witnessed patients being treated with dignity and respect by the reception staff when making appointments or dealing with other administrative enquiries.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected eight completed CQC patient comment cards. These provided a mainly positive view of the service the practice provided. Patients commented that treatment was explained clearly and the dentists put them at ease. They also said that the reception staff were always helpful and efficient.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible management options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. The practice website also gave details of the cost of treatment and entitlements under NHS regulations. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This information was recorded on the standard NHS treatment planning.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including that explained opening hours, emergency 'out of hours' contact details and arrangements. The company web site also contained useful information to patients such as how to book appointments on-line and how to provide feedback on the services provided. There was also information on how to maintain healthy teeth and gums. This ensured that patients had access to appropriate information in relation to their care. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment.

We observed that the computerised appointment diaries were not overbooked and that this provided capacity each day for patients with pain to be fitted into specifically allocated urgent slots for each dentist. Patients were also invited to come and sit and wait if these dedicated slots had already been allocated. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided training for the staff team about this. Information was readily available for staff about the Equality Act 2010 and supporting national guidance. The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. For example, the practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment and hearing loops for the hard of hearing were available at reception. There was level access into the building enabling patients with mobility problems or families with pushchairs and prams to access the practice easily.

Access to the service

The practice was open 9.00am - 5.30pm Monday to Friday. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website and on the telephone answering machine when the practice was closed.

Concerns & complaints

The practice had a complaints process and the practice manager had detailed guidance available about effective complaints handling. The practice had a complaints log that the practice manager sent this to the company head office every month so that the organisation could monitor the number of complaints and the reasons for these. The practice had not received any written complaints during 2015. The complaints generated were from the NHS Choices web site, from which there were six. We saw that these six complaints had been managed in accordance with company policy with a satisfactory outcome for the patients concerned. The practice manager explained that in the event of a complaint they would adopt a very proactive response to any patient concern or complaint. Patients would be spoken to by telephone or invited to a face-to-face meeting in an attempt to resolve the complaint or concern as soon as was practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

The company had in place a comprehensive system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. We saw that these policies and procedures including COSHH, fire and Legionella were well maintained and up to date. Underpinning the governance arrangements for this location consisted of a practice manager who was responsible for the day-to-day running of the practice. The corporate provider had in place a system of area and regional managers who provided support and leadership to the practice manager. The practice had a clinical support manager who was a dentist who provided clinical advice and support to the other dentists. The clinical support manager had appropriate support from a system of clinical directors used by the company.

The company used a system known as 'My Reports' which detailed the performance of the dentist against the NHS commissioner's criteria for quality performance for dentistry in the NHS known as the vital signs report. These were freely available on the company intranet to each dentist at the practice. Dentists were able to analyse their own performance as well as being able to obtain support and guidance from the clinical support manager where there were particular difficulties. The practice manager also explained that they could call upon the clinical support managers if they had concerns about a dentist's performance.

Leadership, openness and transparency

The practice was in a transitional phase from a leadership point of view. The practice had suffered from a succession of practice managers which had affected the morale of the practice. However we found that the new practice manager was determined to improve the situation and had started to strengthen and improve he governance systems of the practice. On the day of our visit we could see that the practice manager had done this and example of this was to ensure that practice meetings were undertaken on a more regular basis. Although the practice manager was managing another sister practice close by, the practice manager was available at all times by telephone if problems occurred at the practice whilst they were working at the other practice. We found staff to be hard working, caring towards the patients and committed and to the work, they did. This was reflected in the comment cards we looked at. Generally staff reported that the practice manager resolved problems as soon as was practically possible. However some of the staffing issues highlighted by staff were beyond the control of the practice manager and could only be dealt with effectively by the company as a whole.

Learning and improvement

Even though there had been a succession of practice managers, the present practice manager found that systems and processes for learning and improvement had always been maintained when they took over at the practice. We saw evidence of systems to identify staff learning needs, this was underpinned by an appraisal system and a programme of clinical audit. We observed that the dental nurses received an annual appraisal; these appraisals were carried out by a practice manager. The dentists also received one to one performance reviews with the practice manager at various times during the year. With respect to clinical audit, we saw results of audits in relation to clinical record keeping, the quality of X-rays and infection control during 2015 and 2016. These indicated that good standards were being maintained by the practice. These audits were used by the company to identify additional training or clinical supervision needs and improve confidence and competence in particular clinical techniques where appropriate.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through the NHS Friends and Family test, NHS Choices, My Dentist, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. We saw that the new practice manager acted proactively when complaints had been raised on the NHS Choices web site. The company used an on-line system for capturing patient satisfaction as well as paper questionnaires known as 'my experience'. A review of these paper questionnaires showed that patients were generally happy with the service provided by the dentists and the caring and friendly approach shown by staff. Out of the 13 questionnaires 10 were very positive about the practice. The system for obtaining feedback through the system of

Are services well-led?

practice meetings will improve now the new practice manager has introduced a system of more regular staff meetings. Previously they occurred around every three to four months.