The Dental Practice

# The Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 18 November 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**

The practice was first established in the 1940's, and is the only practice in the town of Kirkby Stephen. The current practice has been owned by Dr Mirza since 2015. There are currently 900 patients registered with the practice. The provider is in the process of rebranding the practice to Bismillah Smile Studio.

Dental practice is located in a grade 2 listed building with all dental services on the ground floor. The practice provides predominantly private treatment to patients of all ages and NHS treatments for children. There are two treatment rooms, a decontamination room for sterilising dental instruments, a staff room/kitchen and a reception. Access for wheelchair users or pushchairs is possible by a ground floor entrance. Car parking spaces were available in front of the practice and around the market square.

The practice is open Monday and Wednesday 0900-1900, and Friday from 0900-12.30. Tuesday and Thursday there is no dental service available but the reception is open.

The dental team is comprised of the principal dentist, one dental nurse, a trainee dental nurse who also acts as the practice manager, one part-time dental hygienist and one receptionist.

The practice provides general dentistry under private treatment plans.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

# Summary of findings

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.

We reviewed 42 CQC comment cards on the day of our visit; patients were extremely positive about the staff and standard of care provided by the practice. Patients commented they felt involved in all aspects of their care and found the staff to be helpful, respectful, friendly and were treated in a clean and tidy environment.

**Our key findings were:**

- The practice was well organised, visibly clean and free from clutter.
- An Infection prevention and control policy was in place. We saw the sterilisation procedures followed recommended guidance although there was no designated time for the dental nurse to undertake decontamination procedures.
- The practice had systems for recording incidents and accidents.
- Practice meetings were used for shared learning.
- The practice had a safeguarding policy and staff were aware on how to escalate safeguarding issues for children and adults should the need arise.
- Staff received annual medical emergency training. Equipment for dealing with medical emergencies reflected guidance from the resuscitation council.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Patient feedback was regularly sought and reflected upon.
- Patients could access urgent care when required.
- Dental professionals were maintaining their continued professional development (CPD) in accordance with their professional registration.
- Complaints were dealt with in an efficient and positive manner.
- The practice was actively involved in promoting oral health.

There were areas where the provider could make improvements and should:

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society and review the process for the recording of the reason for not using rubber dams when undertaking extensive dental treatments in the patients notes.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review the practice's audit protocols of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Review the practice's procedure when undertaking domiciliary visits with regards to taking the practice's emergency equipment with them.
- Review the use of traditional, unprotected medical sharps and substitute with a 'safer sharp' where it reasonably practicable to do so.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.

# 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?**

No action

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

Infection prevention and control procedures followed recommended guidance from the Department of Health: Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions.

Medicines were stored appropriately, both for medical emergencies and for regular use and were in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff we spoke with were knowledgeable about safeguarding systems for adults and children.

The practice had processes for recording and reporting any accidents and incidents.

Risk assessments (a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) were in place for the practice.

**Are services effective?**

No action

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

Dental professionals referred to resources such as the National Institute for Health and Care Excellence (NICE) guidelines and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations.

Staff obtained consent, dealt with patients of varying age groups and made referrals to other services in an appropriate and recognised manner.

Staff who were registered with the General Dental Council (GDC) met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD).

**Are services caring?**

No action

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

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 42 responses all of which were very positive, with patients stating they felt listened to and received the best treatment at that practice.

Dental care records were kept securely on computer systems which were password protected and backed up at regular intervals.

# Summary of findings

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

The waiting room was equipped with dental information leaflets and magazines .

**Are services responsive to people's needs?**

No action

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

The practice had dedicated slots each day for urgent dental care and every effort was made to see all emergency patients on the day they contacted the practice.

Patients had access to telephone interpreter services when required and the practice provided aids for different disabilities such as a hearing loop. There was no access to a disabled toilet on the premises but staff were able to signpost patients to the nearest one.

**Are services well-led?**

No action

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

We found there were strong support systems in place to ensure the smooth running of the practice.

The principal dentist was on site each day dental treatments were offered. The practice manager had sufficient time to perform the required managerial duties as well as working as a trainee dental nurse. Staff had dedicated roles in the practice, such as infection control.

The practice manager kept all staff files, training logs and certificates and ensured there were regular quality checks of clinical and administration work.

Staff were encouraged to provide feedback on a regular basis through staff meetings and informal discussions.

Patient feedback was also encouraged verbally, via a comments box and a formal patient survey. The results of any feedback were discussed in meetings for staff learning and improvement.

# The Dental Practice

**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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 18 November 2016. It was led by a CQC inspector and supported by a dental specialist advisor.

During the inspection, we spoke with the practice manager, the principal dentist, one dental nurse and the receptionist.

We reviewed policies, protocols, certificates and other documents to consolidate our findings.

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.

No action

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice had systems in place for recording accidents and incidents. Staff were clear on what needed to be reported, when and to whom as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR). There had been no accidents or incidents reported in the practice during the last 12 months.

Staff meetings took place about two monthly where a range of subjects were discussed, including any accidents or incidents, so as to enable staff learning. We viewed minutes of these meetings which were thoroughly documented. As the practice was small, meetings also occurred on an ad-hoc basis if there was something which needed discussing with staff.

The practice manager showed us they had received recent alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness.

**Reliable safety systems and processes (including safeguarding).**

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We were told that the dental nurse was responsible for dismantling any sharps, but guidance in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 states a robust risk assessment be in place to explain why the dentist is not doing this and that the nurses were fully trained to do so. There had been no incidents reported regarding injury with a sharp object.

Flowcharts were displayed in the decontamination room and in each surgery describing how a sharps injury should be managed. Staff advised us of their local policy on occupational health assistance.

The dentist told us they did not use a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We looked at dental records and did not find evidedence of this being recorded.

We reviewed the practice's policy for adult and child safeguarding which contained contact details of the local authority child protection and adult safeguarding. Staff told us their practice protocol and were confident to respond to issues should they arise. The principal dentist was the safeguarding lead and training records showed staff had undergone level one or two training as appropriate.

The practice had a whistleblowing policy which all staff were aware of. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations with the practice manager.

The practice had employers' liability insurance (a requirement under the Employers Liability (Compulsory Insurance) Act 1969) and we saw their practice certificate was up to date.

**Medical emergencies**

The practice followed the guidance from the Resuscitation Council UK and had sufficient arrangements in place to deal with medical emergencies.

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff had received training in basic life support including the use of an Automated External Defibrillator (An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

The practice kept medicines and equipment for use in a medical emergency. These were in line with the 'Resuscitation Council UK' and British National Formulary guidelines. All staff knew where these items were kept.

We saw the practice kept logs which indicated the emergency equipment, emergency drugs and AED were checked weekly with the emergency medical oxygen cylinder being checked monthly. This helped ensure the equipment was fit for use and the medication was within the manufacturer's expiry dates. We checked the emergency medicines and found they were of the recommended type and were all in date.

No action

# Are services safe?

The principal dentist told us that they do undertake domiciliary visits to patients who cannot get to the surgery. They did not take the medical emergencies equipment with them when conducting these visits.

**Staff recruitment**

We reviewed the staff recruitment files for two members of staff to check that appropriate recruitment procedures were in place. Apart from one member of staff all other staff had been employed before the new provider took over. We found files held all required documents including proof of identity, qualifications, immunisation status, indemnity, and where necessary a Disclosure and Barring Service (DBS) check. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children. When recruiting new staff the practice did not take up references for applicants. The practice manager agreed that this would be done in the future.

**Monitoring health & safety and responding to risks**

We reviewed various risk assessments (a risk assessment is a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) within the practice.

We looked at the Control of Substances Hazardous to Health (COSHH) file, the practice risk assessment, health and safety risk assessment and fire risk assessment. These were carried out in 2015/2016 in accordance with the relevant legislation and guidance.

COSHH files are kept to ensure providers contain information on the risks from hazardous substances in the dental practice. We found the practice kept all the products' safety data sheets (these provide information on the general hazards of substances and give information on handling, storage and emergency measures in case of accident) and risk assessments as required by the Health and Safety Executive. We saw annual reviews were in place in line with their risk assessment policy.

We saw annual maintenance certificates of firefighting equipment including the current certificate from August 2016. The practice also had weekly checks of the alarms, extinguishers, lights and fire signs. We could not see evidence that fire drills were carried out to ensure staff were rehearsed in evacuation procedures.

**Infection control**

We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures. All were in accordance with the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health which details the recommended procedures for sterilising and packaging instruments.

We spoke with dental nurse about decontamination and infection prevention and control; the process of instrument collection, processing, inspecting using a magnifying light, sterilising and storage was clearly described and shown. We also saw the daily and weekly tests were being carried out by the dental nurses to ensure the sterilisers were in working order. It was reported that the dental nurse had limited time to decontaminate instruments. Although there were slots booked in during the day these were usually taken over by patient appointments. The dental nurse decontaminated instruments during their lunch time or at the end of the day.

We inspected the decontamination and treatment rooms. The rooms were clean, drawers and cupboards were clutter free with adequate dental materials. There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

The dental unit 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). Staff described the method used and this was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out in July 2015. We saw measures (such as monthly temperature recording and testing of water samples) were implemented and documented.

The practice stored clinical waste in a secure manner and an appropriate contractor was used to remove it from site. Waste consignment notices were available for the inspection and this confirmed that all types of waste including sharps and amalgam was collected on a regular basis.

The practice staff carried out daily environmental cleaning with the practice manager being responsible for general cleaning and the dental nurse responsible for the

treatment rooms. We observed the staff used different coloured cleaning equipment to follow The Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (July 2015).

**Equipment and medicines**

Equipment checks were regularly carried out in line with the manufacturer's recommendations.

We saw evidence of service certificates for sterilisation equipment in March 2016, X-ray machines in March 2016 and Portable Appliance Testing (PAT) in November 2015. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use).

Local anaesthetics were stored appropriately. When local anaesthetics were used information, such as the batch number, was recorded in the patient notes

**Radiography (X-rays)**

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice kept a thorough radiation protection file which included the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, Health and Safety Executive notification, the local rules and maintenance certificates.

We saw all the staff were up to date with their continuing professional development training in respect of dental radiography. The registered provider showed us the practice was undertaking regular analysis of their X-rays through an annual audit cycle in line with the National Radiological Protection Board (NRPB) guidance.

No action

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

We found the dental professionals were following guidance and procedures for delivering dental care.

A comprehensive medical history form was filled in by patients and this was checked verbally at every visit. A thorough examination was carried out to assess the dental hard and soft tissues including an oral cancer screen. Dental professionals also used the basic periodontal examination (BPE) to check patients' gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are.

Patients were advised of the findings and any possible treatment required and were able to discuss this further with the dentist prior to decision making.

The dentist told us they were familiar with current National Institute for Health and Care Excellence (NICE) guidelines for recall intervals, wisdom teeth removal and antibiotic cover. Recalls were based upon the patients' risk of dental diseases.

The dentist used their clinical judgement and guidance from the Faculty of General Dental Practitioners (FGDP) to decide when X-rays were required. The justification, grade of quality and report of the X-ray taken was not always documented in the patient dental care record.

We used guidance from the Faculty of General Dental Practice (FGDP) to help us make our decisions about whether the practice records and record keeping were meeting best practice guidelines.

**Health promotion & prevention**

We found the practice was proactive about promoting the importance of good oral health and prevention. Staff told us they applied the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive care and advice to patients.

Preventative measures included providing patients with oral hygiene advice such as tooth brushing technique, fluoride varnish applications and dietary advice. Smoking and alcohol consumption was also checked where applicable.

The practice reception displayed a range of dental products for sale and information leaflets were also available to aid in oral health promotion.

**Staffing**

Due to the size of the practice the principal dentist was the lead for infection prevention and control, safeguarding adults and children, whistleblowing and complaints.

Apart from the second part time receptionist all staff had been employed in the practice before the new providers took over. There was enough staff to ensure that clinicians never worked unaccompanied but this did sometimes cause time pressure on the qualified dental nurse.

Prior to our visit we checked the registrations of all dental professionals with the General Dental Council (GDC); this was also confirmed on the day of the inspection. The GDC is the statutory body responsible for regulating dental professionals.

Staff told us they were supported and encouraged to maintain their continuous professional development (CPD) and we saw evidence of this in staff files.

**Working with other services**

The principal dentist we spoke with confirmed they would refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. Referral letters were either typed up or pro formas were used to send all the relevant information to the specialist. Details included patient identification, medical history, reason for referral and X-rays if relevant.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

**Consent to care and treatment**

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. Staff explained how individual treatment options, risks, benefits and costs were discussed with each

No action

# Are services effective?

## (for example, treatment is effective)

patient and then documented in a written treatment plan. The patient would sign this and take the original document. A copy would be retained in the patients' dental care record.

Staff were clear on the principles of the Mental Capacity Act 2005(MCA) and the concept of Gillick competence. TheMCAis designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent.

No action

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 42 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

We observed all staff maintained privacy and confidentiality for patients on the day of the inspection. Practice computer screens were not overlooked in reception and treatment rooms which ensured patients' confidential information could not be viewed by others.

We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored electronically and computers were password protected to ensure secure access. Computers were backed up and passwords changed regularly in accordance with the Data Protection Act.

We saw certificates for all staff in information governance training. Staff were confident in data protection and confidentiality principles.

**Involvement in decisions about care and treatment**

The practice provided clear treatment plans to their patients that detailed possible treatment options and costs. The practice's website provided patients with information about the range of treatments which were available at the practice.

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. We looked at dental care records with clinicians which confirmed this.

No action

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

We saw the practice waiting area displayed a variety of information including the practice opening hours, emergency 'out of hours' contact details, complaints and safeguarding procedures and treatment costs. Leaflets on oral health conditions and preventative advice were also available.

The practice had dedicated slots each day for emergency dental care and every effort was made to see all emergency patients on the day they contacted the practice. Reception staff had clear guidance to enable them to assess how urgently the patient required an appointment.

We looked at the appointment schedules and found that patients were given adequate time slots for different types of treatment.

**Tackling inequity and promoting equality**

The practice had a comprehensive equality, diversity and human rights policy in place to support staff in understanding and meeting the needs of patients. The policy was updated annually.

The practice had made reasonable adjustments to prevent inequity to any patient group. The practice had a disability access audit. Patients with mobility impairment could access the practice through a side door. A disability access audit is an assessment of the practice to ensure it meets the needs of disabled individuals, those with restricted mobility or with pushchairs. There was limited access to the patient toilet, via a steep set of stairs into the cellar. There was no disabled toilet facilities in the practice. Practice staff could signpost patients to the nearest disabled facility if this was required. Staff had access to a translation service where required and there were disability aids within the practice such as a hearing loop.

The principal dentist and the practice manager could speak a variety of languages, for example, German, Urdu and Hindu.

**Access to the service**

The practice's opening hours were:

Monday and Wednesday 0900-1900, and Friday from 0900-12.30. Tuesday and Thursday there was no dental service available but the reception was open.

These were displayed in their premises, in the practice information leaflet and on the practice website.

The patients we spoke with felt they had good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

**Concerns & complaints**.

The practice had a complaints policy which provided guidance to staff on how to handle a complaint. The policy was detailed in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and as recommended by the GDC.

Information for patients was available in the waiting areas. This included how to make a complaint, how complaints would be dealt with and the time frames for responses. This information was to be added to the practice website during the rebrand operation.

Staff told us they raised any patient comments or concerns with the practice manager immediately to ensure responses were made in a timely manner. The practice received no complaints in the last twelve months.

No action

# Are services well-led?

## Our findings

**Governance arrangements**

The practice manager provided us with the practice policies, procedures, certificates and other documents. We viewed documents relating to safeguarding, whistleblowing, complaints handling, health and safety, staffing and maintenance. We noted policies and procedures were kept under review by the practice manager on an annual basis and updates shared with staff to support the safe running of the service.

The patient manager kept all staff files, training logs and certificates and ensured there were regular quality checks of clinical and administration work. The practice had an approach for identifying where quality or safety was being affected and addressing any issues. Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members.

We looked at the Control of Substances Hazardous to Health (COSHH) file which contained detailed risk assessments for substances used in a dental practice, their practice risk assessment, health and safety risk assessment and fire risk assessment. Each was in accordance with the relevant legislation and guidance. The practice had dedicated leads and various policies to assist in the smooth running of the practice.

**Leadership, openness and transparency**

The overall leadership was provided by the principal dentist. The ethos of the practice was clearly apparent in all staff as being able to provide the best service possible.

Staff told us they were aware of the need to be open, honest and apologetic to patients if anything was to go wrong; this is in accordance with the Duty of Candour requirements.

**Learning and improvement**

A regular audit cycle was apparent within the practice. An audit is anobjective assessment of an activity designed to improve an individual or organisation's operations.

Clinical and non-clinical audits were carried out but these were not always carried out regularly. Topics included staff and patient feedback, radiography, infection prevention and control and record keeping audits.

The practice manager told us that improvement in staff performance was to be monitored by personal development plans and appraisals which were to be undertaken in January 2017. Staff told us that if they felt they need to undertake any development they could discuss this with the practice manager.

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

The practice had systems in place to seek and act upon feedback from staff members and people using the service.

Staff and patients were encouraged to provide feedback on a regular basis either verbally and using the suggestion boxes in the waiting rooms. The practice also carried out their own survey in 2016. Survey results showed that 100% of patients were happy with the contact to the surgery but only 76% were happy with the waiting time for their appointment. 100% of respondents were happy with the attitude and appearance of staff and 94% were satisfied with the explanations they received. As a result of this survey the practice extended its opening hours until 7pm and introduced longer appointment times for more complex cases.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the practice manager.