John G Plummer & Associates

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 July 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

J G Plummer and Associates is a partnership consisting of 11 practices in the Norfolk and Suffolk area. The New Costessey branch is a mixed dental practice providing primarily NHS treatment to adults and children. The practice is situated in a converted commercial property. The practice has five dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a waiting area, reception area and staff room.

The practice is open from 8.30am to 5.00pm Mondays to Fridays and has16 dentists, including a specialist orthodontist, working there over the course of a week. The dentists are supported by appropriate numbers of dental nurses, receptionists and administrative staff.

One of the provider's partners is the registered manager. A registered manager is a person who is registered with the Care Quality Commission 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 comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 14

Summary of findings

patients. These provided a very positive view of the services the practice provides. Patients commented on the effectiveness of their treatment, the empathetic nature of staff and the high quality of customer care.

Our key findings were:

- We found that the dentists provided patient centred dental care in a relaxed and friendly environment.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Strong and effective leadership was provided by the partnership and senior management team.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared very clean and equipment was well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The was a nominated safeguarding lead and effective processes were in place for safeguarding adults and children.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- There was a 'Happy Smiles' club to deliver tailored preventive advice to children and their parents who were at a higher risk of dental disease.
- Patients could access treatment and urgent and emergency care when required.
- Staff had received training appropriate to their roles and were supported in their continued professional development by the practice owner.
- Staff we spoke with felt well supported by the partnership and senior management team and were committed to providing a quality service to their patients.
- Information from 14 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, professional and high quality service.
- There were areas where the provider could make improvements and should:
- Review the availability of a hearing loop for patients who use hearing aids.
- Review the storage of patient care records and to confirm it is in accordance with current legislation and guidance.
- Review the security of prescription pads in the practice.

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 areas such as infection control, clinical waste, the management of medical emergencies and dental radiography (X-rays). 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 the protection children and vulnerable adults.

No action ✓

Are services effective?

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

Staff had the skills, knowledge and experience to deliver effective care and treatment. 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. A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

No action ✓

Are services caring?

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

We collected 14 completed patient comment cards and obtained the views of a further two patients on the day of our visit. These provided a positive view of the service the practice provided. Patients commented on friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. Staff provided us with many examples of where they had gone above and beyond the call of duty to support and care for patients.

No action ✓

Are services responsive to people's needs?

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

The practice provided a wide range of services to meet patients' needs. Routine dental appointments were readily available, as were urgent on the day appointment slots and patients told us it was easy to get an appointment with the practice. The practice had made adjustments to accommodate patients with a disability. Information about how to complain was available and the practice responded in a timely and appropriate way to issues raised.

No action ✓

Summary of findings

Are services well-led?

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

Strong and effective leadership was provided by the partnership and senior management team.There were robust policies and procedures in place to support the management of the service, and these were readily available for staff to reference

We found staff had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the partners or members of the senior management team, who listened to them.

No action

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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 was carried out on 19 July 2016 by a CQC inspector who was supported by a specialist dental adviser. During the inspection, we spoke with senior members of the corporate team, three dentists, a dental nurse and the practice manager. We reviewed policies, procedures and other documents relating to the management of the service. We received feedback from 16 patients about the quality of the service, which included comment cards and patients we spoke with during our inspection

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 provider's Health and Safety lead demonstrated a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong which also included the reporting of minor injuries to patients and staff. The Health and Safety lead showed us details of a number of accidents and incidents recorded by the practice. These records demonstrated that the reporting forms were completed in full with details of how the incidents could be prevented in future. It was clear that staff learned from adverse incidents that occurred. For example, following a member of staff suffering an asthma attack, an additional oxygen cylinder had been purchased so that one could be available on each floor of the practice.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant these alerts were sent to all practices by the provider's Health and Safety lead for dissemination to staff. Alerts and incidents were also discussed as part of the provider's health and safety meetings that were held quarterly.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste within the practice. This was in accordance with the current EU directive thus helping to protect staff from blood borne diseases. The practice used a safe system whereby needles were not manually resheathed following administration of a local anaesthetic to a patient. Only dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked one of the dentists how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. This was confirmed by the dental nurses we spoke with who showed us the practice's rubber dam kit. (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 could be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the provider's senior management team acted as the safeguarding lead and acted as a point of referral should members of staff have a child or adult safeguarding concern. She had undertaken additional level three training for this role. Records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Staff we spoke with demonstrated their awareness of the different types of abuse, and understood the importance of safeguarding issues. However, some staff were less sure about external organisations should they wish to report an incident out with the practice. Contact details of relevant agencies involved in protecting vulnerable people were available in the staff room, making them easily accessible. We also viewed posters in the patient waiting area giving details on Action on Elder Abuse and the NSPCC.

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 had received training in how to use this equipment. 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 access to oxygen 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 we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole

Are services safe?

team so that they could maintain their competence in dealing with medical emergencies. They had also recently begun medical emergency simulations to ensure staff kept their knowledge and skills up to date.

The practice had a lead member of staff who was responsible for First Aid and their details were clearly on display in the reception area.

Staff recruitment

We checked personnel records for two staff which contained evidence of their GDC registration, employment contract, job description indemnity insurance and a disclosure and barring check (DBS). The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. No references were available for one trainee dental nurse, however we were told that this nurse had trained with the provider so they knew her well. Although recruitment interview notes were not available to view during our inspection, we were assured that these were kept.

Detailed job descriptions were available for all roles within the practice.

Monitoring health & safety and responding to risks

There were procedures in place for monitoring and managing risks to patient and staff safety. A member of the senior management team was the named health and safety lead for the practice and specific meetings were held with staff representatives to discuss a range of health and safety issues across the group. We viewed minutes of the meeting held in June 2016 and saw that incident reports, accidents, pregnancy risk assessments and legislation updates had been discussed with all present.

We viewed a comprehensive risk assessment which covered a wide range of identified hazards in the practice, and detailed the control measures that had been put in place to reduce the risks to patients and staff. The practice had up to date fire risk assessments and carried out regular fire drills with patients which were timed and analysed. Fire detection and firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for products used within the practice..

We noted that there was signage throughout the premises clearly indicating fire exits, X-ray warning signs and identifying the First Aider to ensure that patients and staff were protected.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

The practice had a robust infection control policy that was regularly reviewed. 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 exceeded. We observed that audit of infection control processes carried out in February 2016 confirmed compliance with HTM 01-05 guidelines.

There were comprehensive cleaning schedules and check lists for all areas of the premises. Environmental cleaning was carried out by a combination of the dental nurses and an external cleaner using an agreed cleaning plan. In addition to this a deep clean of the practice was undertaken every December. We saw that the five 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 liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately. Each treatment room had the appropriate personal protective equipment available for staff use including protective gloves and visors. We checked treatment room drawers and found that all instruments had been stored correctly and their packaging had been clearly marked with the date of their expiry for safe use. However we noted some loose and uncovered items in one treatment room drawer. These were within the splatter zone, and therefore risked becoming contaminated over time.

The dental nurse we spoke with described 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). We saw that a Legionella risk assessment had been carried out at the practice by a competent person in September 2015. The recommended procedures contained in the report were carried out and logged appropriately. 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. The dental nurse demonstrated the 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 for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. Data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were 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 in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We noted good infection control procedures during the patient consultation we observed. Staff uniforms were clean, long hair was tied back and their arms were bare below the elbows to reduce the risk of cross infection. We saw both the dentist and dental nurses wore appropriate personal protective equipment and washed their hands prior to treating the patient. The patient was given eye protection to wear.

Records showed that all dental staff had been immunised against Hepatitis B.

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 January 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in February 2015 and were due to be serviced again in 2018. Portable appliance testing had been carried out in February 2016.

The practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

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.

There was a system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned. The practice stored prescription pads in a safe overnight to prevent loss due to theft. There was also a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We did find that two prescriptions in a current batch in one treatment room had been pre-stamped which could lead to their unauthorised use. We pointed this out to the practice manager who assured us that pre-stamping would not occur in future.

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

Are services safe?

maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

We saw that a radiological audit for each dentist had been carried out in November 2015. 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. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The three dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. 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 patients' medical histories were updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and 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 oral hygiene instruction such as tooth 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.

Dental care records we viewed demonstrated 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 tool 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 practice was very focussed on the prevention of dental disease and the maintenance of good oral health. A dental hygienist was employed to provide treatment and give advice to patients on the prevention of decay and gum disease. All of the dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay.

Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. Details of local smoking cessation services were shown on the TV screen in the waiting area for patients.

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.

A number of oral health care products were available for sale to patients including interdental brushes, mouthwash and floss, and free samples of toothpaste were available in treatment rooms. We noted good information in the waiting area about healthier lifestyles, alcohol and exercise, making it easily accessible to patients.

The provider operated a 'Happy Smiles' club to deliver tailored preventive advice to children and their parents who were at a high risk of dental disease. This service was provided at one of the provider's neighbouring practices and was led by dental nurses who had obtained additional qualifications and skills in oral health promotion. Staff visited local schools to deliver talks for children on how to maintain a healthy mouth, and had recently attended the Royal Norfolk show to promote their service and oral hygiene in general. Staff told us they had given out over 400 'goody bags' with information and sample dental products for people.

During our observations, we noted that the dentist gave good oral health advice to one patient who suffered with gum disease. They discussed at length interdental brushing and applied a fluoride varnish to the patient's teeth. They also asked about the patient's dietary and smoking habits.

Staffing

We found that the dentists were supported by appropriate numbers of dental nurses, receptionists and other administrative staff to provide optimum care for patients.

Are services effective?

(for example, treatment is effective)

Staff told us they were enough of them for the smooth running of the practice and a dental nurse always worked with each dentist and the hygienist. There was usually a spare dental nurse on duty and there was access to staff in the provider's other practices if needed.

Files we viewed demonstrated that staff were appropriately qualified, trained had current professional validation and professional indemnity insurance. The practice had appropriate Employer's Liability insurance in place

All staff received an annual appraisal of their performance and had personal development plans in place. Appraisal documentation and personal development plans we saw demonstrated a meaningful and comprehensive appraisal process was in place.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by other clinicians in the provider's group. However complex clinical care could be provided by a number of specialist dentists at the practice including orthodontics (the treatment of misaligned teeth and jaws), oral surgery, dental implants and periodontology (the treatment of complex gum problems). The practice used referral criteria and referral forms developed by primary and secondary care providers such as oral surgery and special care dentistry. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We viewed the practice's patient consent policy which gave good guidance to staff about the various types of consent patients could give and their responsibilities under Mental Capacity Act 2005 (MCA). Staff had signed this policy to show that they had read and understood its contents.

All of the dentists we spoke with had a very clear understanding of patient consent issues. They explained how individual treatment options, their 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. To underpin the consent process one dentist used a computerised patient education system which provided information to assist in the consent process by providing information in video form of the various treatment options available. The system also generated patient information leaflets to supplement the process.

The dentists explained to us how they would obtain consent from a patient who suffered with any mental impairment that might mean that they might be unable to fully understand the implications of their treatment. 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 if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the MCA. Staff 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

Before the inspection, we sent comment cards so patients could tell us about their experience of the practice. We collected 14 completed cards and obtained the views of a further two patients on the day of our visit. These provided a very positive view of the service the practice provided. Patients commented that staff were professional friendly and caring, and told us their dental treatment was pain free and effective.

We spent time in the reception area and observed a number of interactions between the receptionists and patients coming into the practice. The quality of interaction was good, and the receptionists were helpful and professional to patients both on the phone and face to face. Staff gave us examples where they had gone out their way to assist patients. For example, one receptionist delivered a prescription to a very elderly patient who had mobility problems; the practice manager gave a patient a lift home following a difficult extract and dental nurses regularly rang patients to check on their well-being following complex treatment.

The practice had specific policies in relation to data protection and confidentiality and these were available for patients to view on the provider's web site. Reception staff were aware of the importance of providing patients with privacy and maintaining confidentiality. The main reception area itself was not particularly private, and conversations between reception staff and patients could be easily overheard by those waiting. However, staff assured us they could offer a room to any patient who wanted to speak privately All consultations were carried out in the privacy of the treatment rooms and we noted that doors were closed during procedures to protect patients' privacy. Computer screens at reception were not overlooked and all computers were password protected.

We noted that some patients records were kept in paper format on open cabinets behind the reception area. These were not securely stored to maintain the confidentiality of patients' information, or be protected in the event of a fire.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Comprehensive information about various treatments such as root canal, orthodontics and gum disease was available on the provider's web site and leaflets were available for patients in the practice itself. In addition to this, the practice had a specific treatment co-ordinator who offered consultations to patients to discuss treatment options with them.

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 included information recorded on the standard NHS treatment planning forms for dentistry where applicable. During our observation we noted that the dentist took considerable time to explain to the patient the various treatments available to them for managing their gum disease and missing teeth. This included the pros and cons of dentures, bridges, implants and also of leaving the gap.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered a full range of NHS treatments and patients also had access to private treatments including periodontics, endodontics, dental implants and teeth whitening.

During our inspection we looked at examples of information available to people. The waiting area displayed a wide variety of information including the practice's patient information leaflet, how to make a complaint and the practice's quality assurance policy. The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice's website also contained useful information to patients about NHS charges which patients could down load and also how to provide feedback on the services provided. Appointment diaries were not overbooked and provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist which were provided between 12pm and 1pm each day.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. To improve access the practice had level access and treatment rooms on the ground floor for those patients with limited mobility as well as parents and carers using prams and pushchairs. There was also a ground floor disabled friendly toilet. However, there were no easy riser chairs in the waiting area to accommodate patients with mobility needs, and no hearing loop to assist patients with hearing impairments.

Access to the service

The practice was open from 8.30am - 5.00pm Mondays to Fridays**.** The practice used the NHS 111 service to give advice in case of a dental emergency when the it was closed. This information was publicised in the practice's information leaflet, the provider's website and on the telephone answering machine when the practice was closed. Although no extended opening hours were offered, patients told us it was easy to get an appointment at a time that suited them. Patients could be referred to another of the provider's practices which stayed opened until 8pm.

Concerns & complaints

One of the provider's senior managers was responsible for managing complaints and information about how to complain was available in the patient waiting area and also the practice's website. We found that details of other agencies that patients could contact if they were not satisfied with the outcome of the investigation conducted by the practice was not available. However this information was updated in the waiting area during our inspection.

All complaints were discussed at the regular partners' meetings and any learning form them disseminated at the practice meetings. Although no formal complaints had been received by the practice itself, we were shown one complaint that another practice within the provider's group had received. This had been investigated in a timely way and a written response had been made to the complainant. This assured us that complaints would be managed effectively.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of a senior management team which was based at the provider's head office in Caister-On-Sea in Norfolk. This team included lead individuals for infection prevention control, safeguarding, health and safety, training, and information governance. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice. Staff told us the practice was well-led citing effective management, good team working, efficient systems, and access to training as the main reasons**.**

The practice maintained a comprehensive system of policies and procedures which were regularly reviewed by one of the senior partners. Each member of staff given their own folder full of the practice's polices, and updates were given to them when needed, and also discussed at the regular staff meetings. The provider had 11 quality assurance manuals to ensure consistency across all of the sites. We viewed the reception manual which clearly described the daily, weekly and monthly tasks to be completed by reception staff.

Communication across the practice was structured around scheduled meetings. There were separate meetings for the practice managers, for health and safety reps, and dental nurses, as well as staff representatives and partners' meetings. We viewed minutes of a sample of these meetings which were detailed and clearly outlined any action to be taken.

Each year the practice completed an information governance toolkit to ensure it handled patients' information in line with legal requirements. The practice had achieved level 2 on its most recent assessment, indicating it to managed information in a satisfactory way.

Staff received a yearly appraisal of their performance from the provider's training director. The appraisal documentation for dentists we saw was comprehensive and demonstrated a meaningful appraisal process for staff. All staff had personnel developments plans in place

Leadership, openness and transparency

The practice had strong and visible clinical and managerial leadership and governance arrangements in place and a clear vision to deliver high quality care and promote good outcomes for patients. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice's facilities

Staff described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the senior management team and the practice manager. They reported that they were listened to and responded to when they did raise a concern. The staff appeared to be a very effective and cohesive team and told us they felt supported by the senior members of the provider's management team.

Learning and improvement

There was a focus on continuous learning and improvement at all levels within the practice. The provider was an approved training centre for dental nurses undertaking a level three diploma in dental nursing and also acted as a training provider for newly qualified dentists during their probationary year known as Foundation Training.

The practice had up to 15 dentists working over the course of a week, who also worked at the provider's other locations. This was to encourage shared learning and to introduce a fresh approach to patient care that would come from the experiences of different dentists visiting the practices each week. There was a system of peer review and a study club in place to facilitate the learning and development needs of the dentists. These were held on a quarterly basis and provided an opportunity for dentists to discuss dental cases of varying degrees of complexity.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. The partners and senior management team encouraged staff to carry out professional development wherever possible. As a result dental nurses had taken additional qualifications in dental radiography and oral health education. We were told that one dental nurse was training to become a dental hygienist, and another to become a dentist. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The

Are services well-led?

practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays).

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. We also saw that there was an audit of oral cancer awareness in patients. The audits we saw demonstrated that results were analysed to identify where improvements might be needed.

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

The practice encouraged and valued feedback from patients and its staff. For example,

surveys were undertaken to give patients the opportunity to give feedback and influence how the service was run. We were shown the results of the a recent survey where the practice had scored a 95% satisfaction rate based on 65 responses.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results of these were monitored closely by the practice and results were displayed in the waiting area. In response to feedback left, the practice had introduced an email and text messaging service to remind patients about their forthcoming appointments. Feedback left by patients on NHS Choices web site and Google reviews was monitored by one of the partners, who responded to any comments left.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was a specific staff forum meeting, in which elected staff representatives attended. This forum was chaired by one of the senior partners and did not include any dentists or practice managers to encourage a culture of openness . We were given many examples that the provider listened to staff and implemented their suggestions and ideas. For example, as a result of staff suggestions dental nurses now wore trousers instead of dresses to be more comfortable; a daily infection checklist had been introduced, specific practice manager meetings were held and clinical waste had been reduced.