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Silicon Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 September 2015 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

Silicon Dental Centre is located in the London Borough of Ealing. The practice is based on the first floor of the building and access is via the stairs or a stair lift. There is no wheelchair access to the first floor. The practice consists of three treatment rooms, a dedicated decontamination room, an administration office, and a reception area. There are also patient toilet facilities.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, root canal work, veneers, crowns and bridges, tooth extraction, dental implants and oral hygiene.

The staff structure of the practice consists of a principal dentist, three associate dentists, three dental nurses, a hygienist, a receptionist and an administration assistant. Two of the associate dentists were also qualified as vocational trainers and were currently supervising a trainee dentist at the practice.

The practice is open Monday to Friday from 9.00am to 5.00pm.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector and a specialist advisor.

We received 28 CQC comment cards completed by patients and spoke with six patients during our inspection visit. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Risks to patients and staff had been suitably assessed and mitigated
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice had implemented procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Improve the documentation of practice meetings.

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 systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. We found the equipment used in the practice was well maintained and checked for effectiveness.

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. There were systems in place for recording written consent for treatments.

The practice maintained appropriate dental care records and details were updated regularly. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time. Staff engaged in continuous professional development (CPD) and where applicable were meeting the training requirements of the General Dental Council (GDC).

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

We received feedback from patients on the day of inspection and through comment cards. Patients said they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

Patients had good access to appointments, including emergency appointments, which were available on the same day. The practice had access to telephone interpreting services to support people who did not have English as their first language. Members of staff spoke also different languages which supported communication between staff and patients. Although the practice was not accessible by wheelchair, the needs of people with disabilities had been considered through annual audits.

There was a complaints procedure which was available to patients. There were no recent complaints, however we saw that historical complaints had been responded to in line with the practice's policy. The outcomes of complaints were reviewed and discussed at staff meetings in order to identify and share strategies for improving the service.

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

Summary of findings

The practice had good clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Practice meetings were held regularly, however we found the record keeping for these could be improved.

Patients were invited to provide feedback via an annual satisfaction survey, and the Friends and Family Test. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose.

Silicon Dental Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 30 September 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we reviewed policy documents and spoke with seven members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 28 Care Quality Commission (CQC) comment cards completed by patients and spoke with six patients on the day. Patients we spoke with and those who completed comment cards were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. There had been two incidents reported in the past year. One of these related to a needle stick injury and the practice protocol had been followed. There was a policy in place which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'. The principal dentist confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team and social services. This information was displayed in each of the treatment rooms.

An associate dentist took the lead in managing safeguarding issues. Staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues that had required to be reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist.

The practice had carried out a range of risk assessments and the practice had implemented policies and protocols with a view to keeping staff and patients safe. For example, they had an infection control policy, health and safety policies, and had carried out recent risk assessments relating to the safe use of X-ray equipment, fire safety, and access to the premises. We saw that some actions from the recent fire safety risk assessment which was undertaken by external company had been completed. For example, fire safety signs were now displayed in keys areas around the practice as recommended by the risk assessment.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance supplied by 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].

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).The practice held emergency medicines in line with guidance issued by the British National Formulary (BNF) for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely in a central location known to all staff. Records showed weekly checks were made to help ensure the emergency equipment and medicines were safe to use.

Staff recruitment

The practice staffing consisted of a principal dentist, three associate dentists, a trainee dentist, three dental nurses, a hygienist, a receptionist (who was also a qualified dental nurse) and an administration assistant.

There was a recruitment policy in place and we reviewed the recruitment files for seven staff members. We saw that the practice had carried out relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the checking of qualifications, identification, employment history, references, and registration with the General Dental Council (where

Are services safe?

relevant). We noted that it was the practice's policy to carry out Disclosure and Barring Service (DBS) checks for all members of staff and details related to these checks were kept.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced. We also noted that all staff had received training in fire safety.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified, and actions were described to minimise these risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the principal dentist who then disseminated these alerts to the other staff, where appropriate.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area. For example, for the servicing of equipment. There was also an arrangement in place to use the premises of a neighbouring practice to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems in place to reduce the risk and spread of infection. There were policies on infection control, decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the dental nurses was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a decontamination room which was well organised with a clear flow from 'dirty' to 'clean'. There were two sinks, one of which was designated for hand washing use only. A separate bowl which was temperature controlled was used for scrubbing instruments. The dental nurses demonstrated how they used the room and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. After manual cleaning instruments were placed in an ultrasonic cleaner, and following inspection of cleaned items were placed in an autoclave (steriliser). Sterilised instruments were then pouched and stored appropriately until required. All pouches were labelled with an expiry date in accordance with current guidelines.

The dental nurse showed us that systems were in place to ensure that the autoclave and ultrasonic cleaner were working effectively.

These included the automatic control test and steam penetration tests for the autoclave and foil tests for the ultrasonic cleaner. We noted that manual testing of the autoclave was being done at present whilst the practice were awaiting a software upgrade to their equipment. We observed that the data sheets used to record the essential daily validation were always complete and up to date. If the infection control lead was absent or unable to carry out these checks, there was a nominated individual who performed these duties.

Are services safe?

The dental nurse in each treatment room was responsible for cleaning the clinical areas. A named dental nurse was responsible for carrying out general cleaning of the premises, and a domestic cleaner was used when the dental nurse was away. There were clinical and environmental cleaning logs in place, and these were reviewed weekly by the infection control lead to ensure schedules were being effectively followed.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored. The practice used a contractor to remove dental waste from the practice.

The practice had carried out regular infection control audits. Actions were taken where issues were identified as a result of the auditing process.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria and logs of these checks were contained in each treatment room. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A Legionella risk assessment had also been carried out by an external company to ensure regular monitoring of the water systems.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, autoclave, ultrasonic cleaner and X-ray equipment had all been inspected and serviced in 2015. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in September 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The practice did not stock medication other than emergency medicines. Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed within the practice. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. The principal dentist was the radiation protection supervisor (RPS). All clinical staff including the RPS had completed radiation training. X-rays were graded and audited as they were taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we discussed patient care with the dentists and dental nurses and checked dental care records to confirm the findings. We found that the dentists regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). Dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (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.) Different BPE scores triggered further clinical action. The dentists always checked people's medical history and medicines prior to treatment.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients, antibiotic prescribing and wisdom teeth removal. The dentists were aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients. 'Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. Dentists identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health. The practice offered a smoking cessation service which was carried out by a dental nurse and the receptionist. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed health promotion materials in the waiting area. These could be used to support patients' understanding of how to prevent gum disease and how to maintain their teeth in good condition. There was also health promotion information targeted to the demographics of the practice population. For example, we saw posters explaining the ill-effects of chewing oral tobacco products. Patients we spoke with confirmed that clinical staff provided health promotion information to them during consultations.

The practice also provided educational talks at local primary schools to promote good oral health to children and their parents.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and infection control. There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. All new staff members were given a comprehensive practice manual which contained the practice's policies and covered topics such as bullying and harassment, consent protocol, safeguarding, data protection, infection control, and mental capacity.

All staff were engaged in an annual appraisal process whereby their training needs were identified and performance evaluated. We noted the practice had taken action to provide staff with training that had been requested. For example, a dental nurse had undertaken training to become a smoking cessation advisor.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for sedation, oral surgery or advanced conservation. A referral letter was prepared and sent to the local secondary and tertiary

Are services effective?

(for example, treatment is effective)

providers with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff told us they discussed treatment options, including risks and benefits, as well as costs, with each patient. Patients confirmed that treatment options, and their risks and benefits were discussed with them. Our check of the dental care records found that these discussions were recorded. Formal written consent was obtained using standard treatment plan forms, and patients were asked to read and sign these before starting a course of treatment.

Staff were aware of the Mental Capacity Act (MCA) 2005. They described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The MCA 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on the caring and helpful attitude of staff. Patients who reported some anxiety about visiting the dentist commented that the dental staff made them feel comfortable and they were well-supported by the staff. Patients were also complimentary about the quality of treatment provided.

During the inspection we observed staff in the reception area. They were polite, helpful and welcoming towards patients and clearly knew some of the patients well.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically and any paper correspondence was scanned and added to the electronic record. Electronic records were password protected and regularly backed up; paper records were stored securely and were locked up. Staff understood the importance of data protection and confidentiality. Reception staff told us that people could request to have confidential discussions in a private room, if necessary

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and treatment rooms which gave details of NHS and private dental charges or fees. Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There were information leaflets in the waiting area which described the different types of dental treatments available. The patient feedback we received via discussions and comment cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff. They told us that treatment options were well explained; the dentists listened and understood their concerns, and respected their choices regarding treatment. Most patients we spoke to were not local to the area but told us they did not mind travelling to the practice as they were extremely satisfied with the quality of treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment, including scheduling additional time for patients who may need this. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff spoke a range of different languages (Farsi, German, Gujarati, Hindi, Polish, Punjabi, Romanian, Tamil and Urdu) and also had access to a translation service, although they had not had to use this so far. A portable hearing loop was also available for patients/

The practice was based on the first floor of the building and was accessible via stairs or a stair lift. There was no wheelchair access to the first floor. Staff informed us that if a patient was wheelchair bound they would conduct a home visit, or refer the patient to a neighbouring practice who had wheelchair access. The practice carried out a disability discrimination act audit every year. The results from December 2014 showed that the practice had modified and adapted the premises to assist ambulant patients with mobility difficulties. For example, a stair lift had been installed and staff had received manual handling training to assist patients with using the equipment. The equipment was also tested regularly by staff and annually by an external company for safety.

Access to the service

The practice was open Monday to Friday from 9.00am to 5.00pm. The practice displayed its opening hours on their website and in the practice leaflet. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

Patients could book an appointment in advance. Patients told us that they could get an appointment in good time and did not have any concerns about accessing the dentist. In an emergency or outside of normal opening hours, the answer phone message gave details on how to access out of hours emergency treatment. Information about local emergency dental services was also displayed at the practice entrance. Staff told us that all dentists had some gaps in their schedule on any given day which meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated.

Concerns & complaints

There was a complaints policy describing how the practice would handle complaints from patients. Information about how to make a complaint was displayed in the reception area. We were told that one of the associate dentists was the complaints manager, however the practice complaints procedure in the waiting room stated the lead was the principal dentist.

We were told there had been no recent complaints. Records showed that the last complaint received was in December 2011. This had been dealt with in line with the practice policy. The patients we spoke with told us they could approach staff if they wanted to make a complaint.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place, and staff were aware of how to access these. Staff were being supported to meet their professional standards and complete continuing professional development standards set by the General Dental Council. Records relating to patient care and treatment were kept accurately, as were documents relating to staff recruitment and training.

There were some arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. These were being used effectively to drive improvements in a timely manner. For example, advice in the fire risk assessment had been acted on to minimise risks.

Practice meetings were scheduled to take place every month to discuss governance issues, complaints, incidents, patient feedback, audits, health and safety information, and practice protocols. The minutes for these meetings were made available to us however, we noted that some of these lacked sufficient detail and actions to be completed and reviewed at the next meeting had not been clearly addressed.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We spoke with the principal dentist who told us they were committed to both maintaining and continuously improving the quality of the care provided to patients. They had a clear vision about the future of the practice which included providing high quality treatment which was preventative and patient led. They also had a strong training ethos which included setting a positive example for trainee dentists by implementing best practice guidance. Staff were aware of these plans and the overall vision.

We found staff to be caring and committed and overall there was a sense that staff worked together as a team. There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard.

Learning and improvement

The practice had a rolling programme of clinical audit in place. These included audits for infection control, clinical record keeping and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. We looked at a sample of audits which generally revealed a high level of compliance against agreed standards. For example, the bitewing X-ray quality audit showed that 91.25% were grade 1 (no errors), 7.5% were grade 2 (some errors but diagnostically acceptable), and 1.25% were grade 3 (diagnostically unacceptable). Dental care records were also checked to ensure a written report of the radiograph was included, and the audit showed 100% of the radiographs checked had a radiographic report within the records. The audit was repeated every six months to ensure good quality radiographs and avoid repeated exposed to radiation.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

Two of the associate dentists were also vocational trainers and supervised a trainee dentist. They told us that they had made a long-standing commitment to contribute to the development of a new generation of skilled professionals.

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

The practice carried out an annual patient satisfaction survey. We reviewed the results from the May 2015 survey which received eighty responses over a one-week period. The results of this survey were made available to patients in the waiting room. Overall patients rated the practice 'very good', with areas such as helpfulness of staff, being treated with dignity and respect, and feeling confident about the quality of treatment all scoring highly. We noted this positive feedback about staff corroborated our own findings regarding staff's caring attitude. Areas identified as

Are services well-led?

'average' included obtaining an appointment and timekeeping. An action plan was created to address the areas for improvement. For example, we noted that the practice had improved the patient toilet facilities as a result of patient feedback.

The practice also collected feedback through the use of the 'Friends and Family Test'. The practice had received 35 completed 'Friends and Family' tests in the past three months. All of the people completing these tests stated they would be 'extremely likely' or 'likely' to recommend the practice to other people. We saw that patient feedback had been discussed at practice meetings to share any wider learning points which could lead to improvements in the service.

Staff said they could approach management with feedback at any time, and we found the principal dentist was open to feedback on improving the quality of the service. The appraisal system and staff meetings also provided appropriate forums to give their feedback. Staff were positive about the working environment and ability of staff to work together as a team to ensure a high quality service.