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Harley Street Orthodontists

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30September 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

Harley Street Orthodontists is part of a group of five dental practices providing orthodontic treatment (orthodontics is a branch of dentistry that involves the treatment of maligned teeth and jaws). The services are provided on a private basis only and caters for both adults and children. The split between adults and children receiving orthodontic treatment was around 80% and 20% respectively.

The practice is situated in a converted residential property. There is one large dental treatment room that contained two dental treatment delivery units which were separated by glass partitions. The practice has a separate decontamination room for cleaning, sterilising and packing dental instruments and a reception and waiting area. The facilities are on the first floor with a lift enabling disabled access.

The practice has four dentists who are specialists in orthodontic treatment and who all work on a part time basis. A dental nurse provides chair side assistance to the orthodontic specialists; on the day of our inspection a nurse from another of provider's clinic was covering the regular nurse's duties. Supporting the clinical staff are a practice manager, who also manages the other practices in the group, and a receptionist. The practice's opening hours are 9.00am to 5.00pm Mondays to Thursdays.

The Principal Dentist 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'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected eight completed cards and spoke to two patients. These provided a mostly positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

We carried out an announced comprehensive inspection on 30 September 2015 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines with respect to orthodontics.
- All equipment used in the practice was well maintained in accordance with the manufacturer's instructions.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had enough staff to deliver the service.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD)
- Staff felt well supported by the practice manager and registered manager and were committed to providing a quality service to their patients.
- Information from eight completed CQC comment cards gave us a mainly positive picture of a friendly, professional, and caring service.

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

- Consider adding oxygen to the existing emergency check list to prevent oversight of the oxygen capacity and expiry date and hydrostatic testing interval.
- Arrange for staff to receive update training in fire safety.
- Review recruitment procedures to ensure all appropriate records are kept including identity checks and both written and verbal references sought prior to appointment.
- 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 (IRMER) 2000.
- Consider implementing a formal staff appraisal system.
- Arrange for all practice policies and procedures to be dated to identify when they were reviewed and updated.

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 care which was safe in accordance with the relevant regulations.

The practice had good arrangements in place for essential areas of service delivery such as infection control, clinical waste control and management of medical emergencies at the practice. We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children.

The practice had a recruitment policy in place, which included pre-employment checks. However, we noted that the practice had not kept copies of references for all members of staff and we were told some references were obtained verbally but not recorded. In addition there was no record of the pre-employment identity check completed for a recently recruited member of staff.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the British Orthodontic Society to guide their practice. The staff received professional training and development appropriate to their roles and learning needs, although the majority of staff had not received recent fire safety training. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected eight completed cards. These provided an overwhelmingly positive view of the service; we also spoke to two patients who also reflected these findings. All of the patients commented that the quality of care was very good. 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 were mostly satisfied with access to appointments, including emergency appointments, which were available on the same day. Members of staff spoke a range of languages which supported good communication between staff and patients. The practice was able to provide full access to people with disabilities. Patients were invited to provide feedback via satisfaction surveys. There was a clear complaints procedure and information about how to make a complaint was available in the waiting area.

Are services well-led?

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

There were governance and risk management systems in place to guide the management of the practice. This included having appropriate policies and procedures in place, although many of these were not dated and we could

Summary of findings

not readily identify when they were last reviewed. There were regular staff meetings and systems for obtaining patient feedback. The practice had a mission statement in place which was embedded in key practice documents which were shared with all members of staff. Staff were encouraged to raise any issues or concerns with the registered manager or practice manager. Staff we spoke with indicated that they were supported in their roles.

Harley Street Orthodontists

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 30 September 2015.The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with five members of staff, including the practice manager. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area. We reviewed comment cards completed by eight patients and spoke to two patients. Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. There had been one incident reported in the past year. This related to a minor scissors injury to a staff member and the practice had recorded this in its accident book. There was an accident and incident investigation policy in place which was available to all staff on the practice's computer system; this described the actions that staff needed to take in the event that something went wrong or there was a 'near- miss incident'. The practice manager 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. No such incidents had occurred since the practice had opened. We were told that any incidents that did occur would be discussed with staff at practice meetings to communicate lessons learned.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

Systems and processes were in place enabling the practice to escalate safeguarding concerns in relation to children and adults. The practice had a child protection and safeguarding adults policy. This provided staff with information about identifying, reporting and dealing with suspected abuse. The policy was accessible to staff and included the contact details for the child protection team which was on display in reception and available on the practice's computer system. There was, however, no equivalent list for the local vulnerable adults team. The practice manager was the safeguarding lead for the practice. There had been no safeguarding issues reported by the practice to the local safeguarding team. We saw records that confirmed the four dentists, the dental nurse and practice manager had received appropriate safeguarding training. We discussed with one of the dentists on duty the different types of abuse and who to report them to if they came across a vulnerable child or adult. The dentist was able to describe in detail the types of behaviour a child would display that would alert her if there were possible signs of abuse or neglect. The recently appointed receptionist had not yet undertaken formal safeguarding training. However, familiarisation with the practice policy was covered in the induction process and the receptionist was aware of the reporting process in the event of suspected abuse.

The practice had a whistleblowing policy to enable staff raise any concerns of malpractice by other staff members. Staff we spoke with on the day of the inspection were aware of the policy and where to access it on the computer system.

The practice had safety systems in place to help ensure the safety of staff and patients. We spoke with a dental nurse about the prevention of needle stick injuries. She explained that the treatment of sharps and sharps waste (waste orthodontic wire) was in accordance with the current safe sharp guidelines, thus protecting staff against blood borne viruses. The practice did not carry out any invasive dental procedures using local anaesthesia and therefore did not require a risk assessment in relation to local anaesthetic delivery systems. The dental nurse we spoke with was able to explain the practice protocol in detail should a sharps injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments.

Medical emergencies

There were arrangements in place to deal with medical emergencies at the practice. The practice had access to an automated external defibrillator (AED). This was kept on the ground floor and the imaging service that was situated on the ground floor was responsible for its upkeep and maintenance. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.) Staff received team based annual training in how to use this.

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely in a labelled cupboard in the dental treatment room. The expiry dates of medicines were monitored using a monthly check sheet which enabled the staff to replace

out of date drugs and equipment promptly. Oxygen and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines. However we did find that the oxygen tank had passed its expiry date and the tank was just over half full. We informed the practice manager of this fact and she assured us that a new tank would be obtained as soon as possible.

Staff recruitment

The practice staffing comprised four part-time dentists a dental nurse and a receptionist. The practice manager was based at another service within the group but maintained day to day contact with the practice and regularly visited the Harley Street location to exercise managerial oversight. There was an up to date recruitment policy which included pre-employment checks. We reviewed staff records and saw that the practice carried out some relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the checking of qualifications, identification, registration with the General Dental Council (where relevant) and checks with the Disclosure and Barring Service (DBS). However, we noted that the practice had not kept copies of references for all members of staff and we were told some references were obtained verbally but not recorded. We spoke with the recently appointed receptionist who confirmed that a range of checks had been completed before taking up the post including a check of their identity. However, a copy of the identity check had not been kept in the staff records.

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 carried out a number of risk assessments in order to identify and manage risks to patients and staff. For example, six monthly risk assessments for general health and safety were completed. We saw the most recent assessment completed in July 2015 which included action that had been implemented in response to issues identified. The building landlord was responsible for fire safety checks including fire extinguishers checks and periodic fire evacuation drills, and we saw up to date records for these. We were also shown a fire safety audit completed in May 2015 which the practice were acting on to address issues identified. The practice had a designated fire marshal who had received training to carry out this role. Staff received instruction on basic fire safety during induction. However, evidence of update training was not available during the inspection.

There were effective 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. The practice used a COSHH checklist for use when any COSHH changers occurred. We saw that COSHH products were securely stored.

The practice responded appropriately to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts received within the practice were disseminated to staff, as appropriate.

The practice had a business continuity plan in place to ensure continuity of care in the event of a major disruption to the service. This included the facility for using an alternative practice within the group if the service suffered an unforeseen closure.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. An infection control policy was in place supported by written protocols for various stages of the decontamination process. The dental nurse on duty was a nurse who worked at another practice in the group demonstrated the initial cleaning of contaminated dental instruments, sterilisation procedures and the packaging of processed instruments. The nurse was also responsible for carrying out the routine validation tests of the ultrasonic cleaning baths and the autoclaves (devices for sterilising cleaned instruments) on the days she worked at the practice. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01-05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met.

It was noted that the dental treatment room, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in the treatment room areas. Hand washing facilities were available including liquid soap and paper towels in the

Are services safe?

treatment room, decontamination room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

We inspected the drawers in the treatment room areas. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. The treatment room areas had the appropriate routine personal protective equipment available for staff and patient use.

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). The method described by the nurse was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by the landlord of the building. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice utilised a separate decontamination room for instrument processing. This room was well organised, clean, and tidy and clutter free. There were free utility pipes extending from an opening in the ceiling in one corner of the decontamination room but these did not interfere with the decontamination process or present a risk to staff. The practice manager explained that these were in preparation for the possible installation of a clean air flow system that may be installed at a later date. Displayed on the wall were protocols to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available in this room. The dental nurse described to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing followed by ultrasonic cleaning bath for the initial cleaning process; following inspection they were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated that systems were in place to ensure that the autoclaves and ultrasonic cleaning bath used in the decontamination process were working effectively. These included the automatic control test and steam penetration tests. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date. These were later uploaded onto the practices' computer system for archiving.

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

The practice audited its infection control procedures six monthly to assess compliance with HTM 01-05. We saw the most recent audit completed in July 2015.

All of the staff were 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. We saw up to date records of this.

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 September 2015 and the Pressure Vessels Certificate were available for the compressor and autoclaves. These were all within the recommended 26 month time frame between inspections. Due to the nature of the treatment offered by the practice medicines were not prescribed or local anaesthetics administered. The medicines used in the treatment of medical emergencies were available and stored in accordance with current guidelines.

Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety. Implant equipment was always brought in by the visiting specialist. We saw the certificate and report of the latest test completed in August 2015.

Radiography (X-rays)

Are services safe?

The practice did not possess any X-ray equipment themselves to take X-ray images of their patients, instead they used a specialist medical imaging company which was situated on the ground floor to provide this service. As a result of this fact the practice did not need to maintain radiation systems and processes in accordance with the Ionising Radiation Regulations 1999. We observed that an imaging referral form was used to order the various types of X-ray and other images needed for the assessment of patients requiring orthodontic treatment. A review of a sample of patient records which contained the digital X-ray images of patients showed that the quality of images was exceptionally good. Although the practice did not need to conform to the Ionising Radiation Regulations 1999, compliance was still required with respect to Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This requires dentists who refer patients for X-rays to review and report on these X-rays unless this was requested on the referral form. On the sample of dental treatment records we observed this was not always the case. Also the written justification was not clear in the notes from the sample of records we observed. It was not clear in the dental treatment records if X-rays were provided by the referring practitioner or the imaging service.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients were seen by the practice for orthodontic treatment either by a professional referral or self-referral basis only. If routine dental treatment need was identified as part of the orthodontic assessment; this would be carried out either by the patients referring dentist or the patient would be signposted for treatment before treatment was commenced or during mid treatment if necessary.

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines in relation to orthodontics. We spoke with two dentists on the day of our visit. They described to us how they carried out patient assessments. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the written medical history was scanned into the computerised record system on all of the four dental treatment records we sampled. This was followed by discussing the reasons for referral.

Following this an examination of the jaw relationships and the degree of tooth crowding irregularity took place. The dentists also assessed the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options were explained to patients.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products and advice leaflets. 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. We saw examples of the patient letters that were sent following assessment, these contained details of the clinical findings, the proposed treatment and indicative costs of the treatment. Patients we spoke with confirmed that they received such information.

We were invited, with the patient's agreement, to observe a treatment session where we saw the orthodontic specialist carry out treatment in a very kind and caring way. She explained treatment very thoroughly reinforcing what had been carried out previously, the treatment provided on the day and the treatment proposed for future appointments. The specialist also reinforced the importance of maintaining good oral hygiene practises to prevent gum problems and dental decay during the duration of the orthodontic treatment.

The practice used a computerised system for maintaining patients' dental care records which were password protected. We were told wherever possible written medical history forms, referral letters, laboratory dockets and treatment plans with costs were scanned into the computer system. A check of a sample of dental care records showed that the details of the individual orthodontic treatment carried out was recorded in detail. All medical histories and patient treatment letters, photographs and X-ray images were uploaded onto the system.

Health promotion & prevention

Following assessment and acceptance for treatment patients were given an oral health pack containing leaflets about effective dental hygiene and how to reduce the risk of poor dental health whilst undergoing treatment. Patients were also supplied with various tooth brushes to maintain good oral health while the patient is wearing orthodontic braces. The waiting room and reception area at the practice also contained literature in leaflet form that explained the services offered at the practice. For those patients who found it difficult to maintain good oral hygiene during treatment, referrals were made to a dental hygiene service opposite the practice. Here patients could obtain intensive oral hygiene instruction and professional cleaning.

Staffing

There were arrangements in place to support staff in their professional development and training. This included training in mandatory topics such as basic life support, infection control, and safeguarding. An induction

programme was in place for all new staff tailored to individual job roles. Staff were not engaged in a formal appraisal process whereby their training needs were identified and performance evaluated. We were told there were meetings with staff individually to discuss training needs, however these were informal discussions and were not documented.

The practice manager told us there were sufficient staff to meet needs and staff were always available from within the group of practices to cover absences such as annual leave and sickness.

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. Referrals when required were made to other dental specialists. We noted the record of one such referral to an oral and maxilla facial surgeon where a patient required extensive surgery prior to receiving orthodontic treatment. Scanned into the patients record was the referral letter, letter of acknowledgement from the specialist along with the letter explaining the treatment carried out and copies of appropriate dental X-rays. The four specialist orthodontists had particular specialist interests within orthodontics. This enabled inter-practice referrals to take place so that patients could receive the most appropriate care for their individual problem.

Consent to care and treatment

The two dentists we spoke with who were on duty on the day of our visit both had a clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a patient review letter. The review letters were always scanned into the patient's dental care records. 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. Both specialists we spoke with explained how they used an intra-oral camera to take photographs of the teeth prior, during and at the end of orthodontic treatment. This included the condition of teeth requiring treatment, the appearance of the gums and of the soft tissues. These provided a means of patient education as well as preventing medico-legal problems in cases where patients could dispute the dentist's findings and treatment outcomes.

One specialist we spoke with on the day of our visit explained how they would obtain consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. She explained if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. She explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Although there were two dental units in the same room, an extensive glass partition divided off each unit. Due to the listed status of the building a complete floor to ceiling partition was not possible. However, the dentists all worked different days so the two units were never in use at the same time and patient dignity and privacy was never compromised. The treatment room was situated away from the main waiting area and we saw that doors were closed at all times patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected the patient's privacy. Dental care records were stored electronically and computers were password protected. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. During the patient treatment session we observed the patient was treated with respect, dignity and empathy throughout the whole session.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients which detailed possible management options and indicative costs. The practice web site provided details of the indicative costs of the services provided. The specialists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the sample of dental care records we looked at that the specialists recorded the information they had provided to patients about their treatment and the options open to them.

The patients we spoke with and CQC comment cards reported that patients had been involved in decisions about their care and treatment. Patients stated that treatment options were clearly explained; the dentists listened to and understood their concerns, and respected their choices regarding treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

This practice catered for patients who had a specific need in relation to the appearance of their teeth, face and jaws as a result of teeth and jaw malalignment. During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a patient information folder which contained comprehensive information about the services provided for patients. The practice had a website which also provided comprehensive information about the types of treatment on offer and the indicative costs. Patient information leaflets were available in the waiting area and treatment rooms. These gave information about caring for teeth and gums during orthodontic treatment and specific treatments in relation to orthodontics.

We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. Patients we spoke with said they were happy with the appointments system. One of the eight CQC comment cards we received indicated general satisfaction with the service but expressed dissatisfaction with the waiting time when attending for appointments.

Tackling inequity and promoting equality

The practice was able to offer full access for disabled patients and there was a lift to the first floor to where the dental facilities were located. The practice had an equality and diversity policy which was covered during induction. Staff had not received formal training in equality and diversity issues but had been made aware of the practice policy and during continuing professional development in covering legal and ethical issues. Staff spoke a range of different languages (including Farsi, Romanian, Russian, Portuguese, Spanish, Chinese and German) and also had access to a translation service.

Access to the service

The practice was open Monday to Thursday from 9.00am to 5.00pm. The practice manager told us the practice was able to accommodate urgent appointments through extended appointments after 5.30pm during the week and also at weekends if needed. On Fridays when the practice was closed, urgent appointments were taken up by other practices within the group. The practice displayed its opening hours at their premises.

Feedback from patients we spoke with indicated they could get an appointment in good time and did not have any concerns about accessing the dentists.

Concerns & complaints

The practice had a complaints policy and procedure in place which provided staff with guidance on how to support patients who wanted to make a complaint. This included details of organisations with whom patients could pursue matters further if they were not satisfied with the practice's handling of their complaint. The practice manager was the lead for complaints handling. Staff we spoke with were aware of the process to follow in the event of a complaint arising.

We found there was a system in place to investigate and communicate with patients regarding complaints which provided for an investigation and timely response. There had been no formal complaints since the practice had been in operation.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service working alongside the principal dentist. They ensured there were systems to monitor the quality of the service and make improvements where necessary. There were relevant policies and procedures in place, although many of these were not dated and we could not readily identify when they were last reviewed. There were meetings every four to six months which involved staff at all five practices within the group, and two weekly meetings at the practice between the principal dentist, practice manager and receptionist. Meeting minutes were retained and we were shown a sample of these. There were also regular informal meetings to discuss day to day issues.

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 or practice manager. They felt they were listened to and responded to when they did so. At team meetings staff were encouraged to put forward ideas and we saw from minutes that they were kept fully informed of important issues and developments. For example, at a meeting in March 2015, the reallocation of duties was discussed and agreed in the light of staffing changes.

The practice had a mission statement set out in the practice's quality assurance policy and in its statement to patients entitled 'Working together'. This stated; 'we are committed to providing the highest possible standard of care for our patients. An important part of fulfilling this commitment is ensuring that we work in partnership with you.' This was communicated to staff during induction and reviewed periodically.

The practice did not have a formal appraisal system to support staff and identify their training and career goals. The practice manager told us they had regular one-to-one sessions with staff to cover such topics, however these meetings were informal and not documented. The practice manager told us they would consider the implementation of a formal staff appraisal process. The staff we spoke with all told us they enjoyed their work, were well-supported by the management team, including meeting their training needs.

Learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that the dentists were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice undertook regular audits. These included audits for infection control and health and safety. In addition, to ensure that the patient outcomes were optimal the orthodontists used a specific outcome measure for orthodontic treatment. This is known as Peer Assessment Rating or PAR scoring. This system assesses the quality of treatment by comparing the alignment of the teeth before and after treatment using plaster of paris models of the patient's teeth.

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

The practice had systems in place to seek feedback from patients using the service, including carrying out an ongoing patient survey. The practice monitored feedback forms and took action in response to trends or any adverse comments identified. The feedback to date had been positive and no improvement action had been identified.

The practice undertook periodic staff surveys with individual members of staff and we saw the latest survey completed by the recently appointed receptionist. This covered issues such as what the staff member liked about the practice, what would make their work more satisfactory, what had affected their work in the last six months, and what changes they would like to see. The survey also included a wide range of questions related to employment at the practice using a six point scale. The practice manager had yet to review the survey response.