Care Quality Commission

Rodericks Dental Limited

Hill Street Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Hill street Dental Practice, part of a corporate dental body, is a mixed dental practice providing mainly NHS and some private treatment for both adults and children. The practice is situated in a health and well-being medical centre. The practice had three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Dental care was provided on ground floor accommodation with a reception and waiting area.

The practice is open 8:30am to 5:30pm Monday to Friday. The practice has four dentists who are supported by five dental nurses and a receptionist. The practice also has a dental hygienist who works one day per week.

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

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to complete to tell us about their experience of the practice.

Summary of findings

We received feedback from 12 patients. These provided a completely positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

Our key findings were:

- The practice ethos was to provide patient centred care.
- The practice benefitted from an empowered practice manager who provided robust leadership within the practice and was supported by an equally empowered area manager.
- Staff had been trained to handle emergencies and appropriate medicines together with life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead with effective safeguarding processes in place for safeguarding adults and children.
- The service was aware of the needs of the local population and took those these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The practice had enough staff to deliver the service.
- Staff recruitment files were well organised and complete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from 12 completed Care Quality Commission (CQC) comment cards gave us a completely positive picture of a friendly, professional service.
- The practice had received very few complaints.
- The practice had a rolling programme of clinical and non-clinical audit in place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

Are services effective?

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

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

Are services caring?

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

We collected 12 completed CQC patient comment cards; these provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and all dentists were good at explaining the treatment that were proposed.

Are services responsive to people's needs?

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

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

Are services well-led?

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

The practice manager and other 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 practice manager. All the staff we met said that the practice was a good place to work.

Hill Street Dental Practice

Detailed findings

Background to this inspection

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

The inspection took place on 22 March 2016; the inspection was led by a CQC inspector who was supported by a dental specialist advisor. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members and proof of registration with their professional bodies.

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an adverse incident reporting policy and standard reporting forms for staff to complete when something went wrong. The policy contained clear information to support staff to understand the wide range of topics that could be considered to be an adverse incident. The practice also had an appropriate accident record book which was used correctly to protect the privacy of individuals filling in the forms. We saw evidence of a recent incident that occurred in the practice. We found that the incident reporting forms had been completed in line with company policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. The area manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every four weeks.

Reliable safety systems and processes (including safeguarding)

We spoke to the practice manager about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. Policy and a protocol was in place to support compliance with the EU directive. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. A needle guard system was in place to assist in recapping a used needle. The lead dental nurse was also able to explain the practice protocol in detail 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. There had been no needle stick injuries during 2015.

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

The practice had a nominated individual, the practice manager, who acted as the practice safeguarding lead. This individual acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse. Training records showed that all staff had received safeguarding training for both vulnerable adults and children within the past 12 months. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

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

The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled the staff to replace out of date medicines promptly. The AED was checked on a daily basis. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. We found that all staff had received update training in 2015.

Staff recruitment

All of the dentists, dental hygienist and dental nurses where appropriate had current registration with the General

Are services safe?

Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are 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.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The organisation maintained a comprehensive system of policies and risk assessments and included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice manager acted as the lead for infection prevention control. 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. We saw that an audit of infection control processes carried out in March 2016 confirmed compliance with HTM 01 05 guidelines.

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

The drawers of the treatment rooms were inspected and were found to be clean, 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. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

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

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). They described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in April 2015. The recommended procedures contained in the report were carried out and logged appropriately. This included regular testing of the water temperatures of the various taps in the building. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. This room was organised, clean, tidy and clutter free. Dedicated hand washing facilities were available in this room. The dental nurse demonstrated the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Are services safe?

The practice used a system of manual scrubbing for the initial cleaning process, following inspection they were placed in an autoclave (a device used to sterilise medical and dental instruments). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The dental nurse also demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily 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 and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice and was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in September and January 2016. The practices' X-ray machines had been serviced and calibrated in July 2015. Portable appliance testing (PAT) had been carried out in September 2014 .The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. NHS prescription pads were stored in a safe overnight to prevent theft. The pads were also logged in and out each day to prevent to prevent loss. We saw that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

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

A copy of the radiological audits for each dentist carried out in 2015 and 2016 demonstrated that a very high percentage of radiographs were of a high standard of quality in terms of positioning and processing. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke to two dentists who described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums 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 dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A review of a sample of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is 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 focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. One dentist we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications 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. Patients were given advice about tooth brushing techniques explained in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. 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. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

There were enough staff to support the dentists during patient treatment. The area and practice manager told us that the practice ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to support staff development including internal company training and staff meetings as well as attendance at external courses and conferences. The organisation provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and other specific dental topics. We saw training records that confirmed this was so.

Working with other services

The practice manager explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers. This ensured that patients were seen by the right person at the right time. We noted the practice used a referral tracking system to monitor referrals from the practice.

Consent to care and treatment

We spoke to two dentists on duty on the day of our visit; they both had a clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and

Are services effective?

(for example, treatment is effective)

then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

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

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 12 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient.

Involvement in decisions about care and treatment

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including that explained opening hours, emergency 'out of hours' contact details and arrangements. The organisation web site also contained useful information to patients such as how to provide feedback on the services provided. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with pain to be fitted into specifically allocated urgent slots for each dentist. Patients were also invited to come and sit and wait between 8.30 and 10.30am. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided training for the staff team about this. Information was readily available about the Equality Act 2010 and supporting national guidance. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The area manager explained they would also help patients on an individual basis if they were partially sighted or hard of hearing to go through NHS and other forms.

Access to the service

The practice is open 8:30am to 5:30pm Monday to Friday. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the reception, waiting areas, practice information leaflet and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

The practice manager explained that in the event of a complaint they would adopt a very proactive response to any patient concern or complaint. Patients would be spoken to by telephone or invited to a face-to-face meeting in an attempt to resolve the complaint or concern as soon as was practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

The organisation had in place a comprehensive system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. We saw that these policies and procedures including COSHH, fire and Legionella were well maintained and up to date. We saw examples of monthly staff meeting minutes which provided evidence that training took place and that information was shared with practice staff. The minutes of the meetings we saw were comprehensive and detailed. The meetings were used to discuss all aspects of the running of the practice and the care and treatment it provided to patients. This included patient feedback, health and safety, infection control, audit reports and company updates.

Underpinning the governance arrangements for this location consisted of a practice manager who was responsible for the day-to-day running of the practice. The corporate provider had in place a system of area managers who provided support and leadership to the practice manager. The practice had a clinical adviser who was a dentist who provided clinical advice and support to the other dentists and dental nurses working in the practice. The clinical adviser had appropriate support from the company clinical director.

The organisation used an intranet portal system which detailed the performance of the dentist against various quality criteria, this included details of record keeping audits, their reflections on any patient complaints they had received, appraisal and CPD requirements.

Leadership, openness and transparency

The practice ethos was to provide patient centred care, underpinning this was a practice that benefited from an empowered area manager and practice manager. We found staff to be hard working, caring towards the patients and committed and to the work, they did. We saw evidence from staff meetings that issues relating to complaints and compliments, practice performance including the quality of care provided was openly discussed and addressed by the whole team. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry. All of the staff we spoke with were happy with the facilities and felt well supported by the practice manager and area manager. Staff reported that the practice manager was proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs, this was underpinned by an appraisal system and a programme of clinical audit. We saw that the dental nurses received an annual appraisal; these appraisals were carried out by the practice manager and area manager. New dental nurses received regular three monthly reviews up to their first annual appraisal. The dentists received one to one performance reviews with a clinical adviser. With respect to clinical audit, we saw results of audits in relation to clinical record keeping, the quality of X-rays and infection control which demonstrated that good standards were being maintained. These audits were used by the company to identify additional training or clinical supervision needs and improve confidence and competence in particular clinical techniques where appropriate.

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

The practice had gathered feedback from patients through the NHS Friends and Family test, NHS choices, compliments and complaints. We saw a log of NHS choices comments for 2015; all twenty five comments were very positive about the staff and the quality of care provided. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area and practice leaflet. The company used an on-line system for capturing patient satisfaction as well as paper questionnaires. Displayed in the waiting room were the results from a 'you said we did' approach for March 2016. As a result of patient feedback improvements were made to administrative processes and the availability of patient information in the waiting area.

Staff told us that the practice manager was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had monthly meetings; the minutes of these were made available if they could not attend. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.