Parkfield Dental Surgery Limited

Parkfield Dental, Berrow Health Campus

Inspection Report

Berrow Health Campus
Brent Road
Burnham-On-Sea
Somerset
TA8 2JU
Tel: 01278 781064
Website: www.parkfielddental.co.uk

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out an announced comprehensive inspection on 6 February 2017 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?

Summary of findings

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

Parkfield Dental, Berrow Health Campus is located in the coastal town of Burnham-on-Sea, Somerset. The practice is purpose built and provides primary dental care services for people who require dental procedures. The practice provides mostly NHS care with some private treatments. There are three dental surgeries all situated on the ground floor. There is level access from the street and parking, including parking for disabled patients at the practice. Approximately 5,000 patients are registered at the practice.

The staff structure of the practice consists of three dentists, one dentist in their foundation year after qualifying as a dentist and a dental hygienist. There is a practice manager, three dental nurses, one trainee dental nurse and two receptionists. Dental nurses also act as reception staff. The practice is a training practice for dentists in their foundation years after graduating.

The practice is open from Monday to Friday from 8.30am to 5.00pm (with extended opening until 7.00pm on Mondays, Tuesdays and Wednesdays). There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

The registered manager is the company manager who works as a dentist in one of the other company locations in Somerset. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

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

Fourteen patients provided feedback directly to CQC about the service. All were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received.

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.
- There was a lead staff member for safeguarding patients. All 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.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment text/phone reminders were available on request up to one week prior to appointments.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff received training appropriate to their roles and were supported in their continued professional development by the management team.
- Staff we spoke with felt supported by the practice manager and were committed to providing a quality service to their patients.

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

Summary of findings

- Clarify and formalise clinical leadership roles at the practice.
- Improve staff meeting record keeping and circulate meeting minutes to the whole staff team.
- Implement a system for the recording of prescriptions issued to patients.
- Implement a system for the formal analysis of clinical audits.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies.

There were systems for identifying and investigating incidents relating to the safety of patients and staff members. However, learning from such events was not effectively discussed with the whole staff team because meeting minutes were not circulated to the staff team.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. There was an annual training plan to ensure staff training in safeguarding was appropriately maintained.

Infection control processes were safely managed. Equipment used in the practice was checked for effectiveness. Medicines were safely managed; however, there was a lack of record keeping of prescriptions issued to patients. Staff recruitment was robust ensuring that applicants had the skills and aptitude for their employed roles.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Clinical audits were carried out but formal analysis of these audits needed improvement.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received positive feedback from 11 patients. The practice also received patient feedback via internal surveys and through the NHS Choices website. Feedback was consistently positive. Patient survey results were complimentary about the practice staff and treatment received. Patient survey results said that the staff were kind and caring and that they were treated with dignity and respect at all times.

Summary of findings

We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

No action 

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.

There was a complaints policy in place. Complaints were addressed in a timely way and resolutions aimed to the satisfaction of the complainant. Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included patient testimonials sent directly to the practice. Systems were in place to publicise responses from the practice about what had been done as a result of patient feedback.

The culture of the practice promoted equality of access for all. There was equipment available for patients who had hearing impairment and facilities for people with limited mobility, or wheelchair users had been considered when the building was designed and provided accessible facilities.

Are services well-led?

No action 

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

The practice had a practice manager and risk-management structures in place. The clinical leadership role at the practice was unclear and needed clarification. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the practice manager. They were confident in the abilities of the manager to address any issues as they arose.

Clinical audits took place but results were not always shared with dentists for learning opportunities.

Parkfield Dental, Berrow Health Campus

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.

We carried out an announced, comprehensive inspection on 6 February 2017. The inspection was led by a CQC inspector and a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with eight members of staff (practice manager, three dentists, one dental nurse, one trainee dental nurse and two receptionists). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Fourteen patients provided feedback about the service. We also looked at written comments about the practice left about patient experiences on-line via NHS Choices. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients commented that they were likely to recommend 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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting incidents. There had been no significant events related to patients in the past year.

We discussed the investigation of incidents with the practice manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour, although the term 'candour' was not immediately recognised by one of the dentists and we explained this to them.

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.

Whole staff team meetings were held and the last meetings were held during October and November 2016. The registered manager did not attend these meetings. Team meetings were recorded and we looked at the team meeting minutes from October and November 2016. There was no system to capture if actions resulting from team meetings were addressed and signed off as completed. Minutes were also not circulated to the team. If a staff member had not attended the meeting they could be unaware of issues discussed. We raised this with the practice manager who told us they would review and revise the meeting minute template, circulate minutes to the whole team and record who was taking the clinical lead in staff meetings if the registered manager was unable to attend.

Reliable safety systems and processes (including safeguarding)

The practice manager was the named practice lead for child and adult safeguarding. We spoke with the practice manager and dentists who were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a safeguarding policy, which was reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the staff room. The staff we spoke with were aware of the location of this information. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to level two. In addition the practice manager and area manager had completed safeguarding to the recommended enhanced level three for safeguarding leads.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice had arrangements to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated with the emergency equipment in an area accessible only to staff. This was available for the dental practice to use; the staff were aware of its location and how to use it. (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 for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Oxygen was stored in a room that had a notice of

oxygen storage displayed inside this room. We commented to the practice manager that the notice should be on the outside door to the room to alert fire fighters in the event of an emergency.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use on a weekly basis.

Staff recruitment

The staff structure of the practice consisted of three dentists, a dentist in their foundation year after graduating and a dental hygienist. There was a practice manager (who was a qualified dental nurse), three qualified dental nurses, one trainee dental nurse and two receptionists.

Many of the staff had been in post for a number of years. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS checks 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). We looked at two staff files. All required information was included in the files we viewed.

Monitoring health & safety and responding to risks

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. The practice carried out fire drills. The last was carried out during December 2016.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. COSHH products were securely stored.

The practice had a system for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS). The practice manager said alerts were printed off and circulated to clinical staff who signed to acknowledge that they had read them.

Infection control

There were effective systems to reduce the risk and spread of infection within the practice. There was an infection control policy, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The lead infection control nurse carried out bi-annual audits of infection control processes at the practice using a recognised industry assessment tool.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment and decontamination rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment and decontamination rooms.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice 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)'.

The dental nurse explained the decontamination in the purpose built decontamination room and dental surgeries. The dental nurse described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

We noted that the temperature in the decontamination room was very warm. The practice manager said this was an ongoing issue and they had raised this with the landlord and had sought industry advice. We were told the air flow extraction system in the room was working correctly. The practice manager said that it would not be appropriate to allocate one dental nurse to work solely in the

decontamination room whilst on duty due to the excessive heat in the room. We saw that dental nurses had suitable breaks from working in this room. In the meantime the practice manager said they were still looking for solutions to the heat comfort issue in the room.

We checked the contents of the drawers in all of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use. We noted, however, that local anaesthetic cartridges were stored loosely individually and not in recommended sealed blister packs to minimise cross infection. We raised this with the practice manager who told us they would revise this storage to the recommended guidance.

Instruments were cleaned in washer disinfector units or, if required, manually cleaned. Items were then inspected under a light magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

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. The practice used a contractor to remove dental waste, which was stored securely outside the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

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. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

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 practice manager described the method they used which was in line with current HTM 01-05 guidelines. A legionella risk assessment had most recently been carried out by an external contractor during April 2016. The practice was following recommendations to reduce the risk of legionella, for example, through the regular testing of the water temperatures. The practice kept a record of the outcome of these checks on a monthly basis.

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, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance in December 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration were stored in a fridge in line with the manufacturer's guidance. We noted the practice had no system for logging number ranges of prescription pads for security and auditing purposes. In addition individual prescription script numbers were not recorded in patient notes. We raised this with the practice manager who said they would take this forward with the company senior manager to devise and implement a system.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000

No action

Are services safe?

(IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in 2015, within the three yearly recommended maintenance cycle.

We saw evidence that the dentists had completed radiation training in the last 12 months.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists and hygienists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with three dentists and asked them to describe to us how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient on request, which included information about the costs involved whether private or NHS. Patients were referred to the practice information leaflet, or website for cost information on routine treatments (the practice website was in the process of being reviewed and was temporarily unavailable). Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of four dental care records to confirm the findings. These 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 and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Dentists told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

Many of the staff employed had worked at the practice for a number of years. Staff told us that the management team were supportive and invested in their staff through regular training opportunities to promote clinical excellence at the practice.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. The dentists and hygienist were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent by post or by fax in the case of urgent referrals (such as for suspicious mouth lesions) to the hospital with full details of the dentist's findings and a copy was stored on the practice's records system. We looked at three examples of letter templates for referral to secondary care or for specialist treatment such as orthodontics. The

No action

Are services effective?

(for example, treatment is effective)

receptionists told us they kept an electronic referrals log noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at four patient electronic records and saw consent to treatment was suitably recorded in the patient dental care records.

All of the staff were aware of the Mental Capacity Act 2005 (MCA). The MCA 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. Clinical staff had completed formal training in relation to the MCA. The dentists could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The seven comments cards we received and discussions with seven patients on the day of the inspection, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and the dentists/hygienist could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated lockable staff only area. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice detailed information about services in the practice leaflet available at the reception and on display in the patient waiting area. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes). A poster detailing NHS and private treatment costs was displayed in the waiting area and at the reception desk.

We spoke with eight staff on duty on the day of our inspection. All of these staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

The patient feedback we received on the day of the inspection confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' dental needs. The dentists and hygienist decided on the length of time needed for their patient's consultation and treatment according to patient need. Additional same day urgent appointments were also scheduled for patients registered with the practice. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they provided written information for people who were hard of hearing and translation services were available for patients speaking English as a second language. There were both female and male dentists to facilitate requests for same gender examinations or treatment.

The practice was purpose built and opened in 2011. It was designed with patient accessibility in mind. Patients who used a wheelchair could access the practice from the ground level access and there were ground floor treatment rooms with an accessible ground floor toilet. There was disabled parking immediately outside the practice. The seating in the waiting area was designed so that people with impaired mobility would have arm rests on chairs to help them to sit/stand. We received a comment from one patient that there was no space in the waiting area for people using wheelchairs to park without blocking the seats of other patients. We raised this observation with the practice manager who said they would consider this with a view to rearranging available seating in the waiting room to accommodate wheelchair users.

Access to the service

The practice opening hours were from Monday to Friday from 8.30am to 5.00pm (with extended opening until 7.00pm on Mondays, Tuesdays and Wednesdays). There was an answer phone message directing patients to emergency contact numbers when the practice is closed.

The receptionists told us that patients, who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice of their concerns. The feedback we received via comment cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been nine complaints recorded in the last 12 months regarding dental work or fees. We looked at the complaints in detail. They were handled in a timely way and resolved to the satisfaction of the patient complaining.

Patients were also invited to give feedback about the practice. The practice used patient surveys, in which patients could remain anonymous. Patients were asked if they would like to take part in a survey about their dental treatment on each visit. We saw examples of 28 responses in 2016. All responses were complimentary about the practice staff and treatment received. Comments left by patients on the NHS Choices were also complimentary about the practice.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. The governance arrangements for this location were overseen by the practice manager who was responsible for

the day to day running of the practice. They were supported by the group's area manager and company manager (registered manager). We were unsure of the practice's structure of clinical leadership. We asked the practice manager who was the clinical lead at the practice. They said this was the registered manager and that a senior dentist at the practice also had a number of clinical responsibilities, such as overseeing the supervision of dentists in their foundation year after graduating. The practice manager and dentists told us they had email access to the registered manager for advice and were aware of an in-house social media group being created, for example to share clinical expertise and aid communication between the three locations in the company. However, staff told us that the registered manager did not visit the practice regularly and had not attended the last two staff meetings. We expressed concerns about the clinical leadership roles and responsibilities at the practice, including delegated responsibilities such as representation at staff meetings. The practice manager said they would relay our findings to the registered manager with a recommendation that clinical lead roles and responsibilities be agreed and formalised at the practice.

At the practice there were relevant policies and procedures in place. Staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

A systematic process of induction and staff training was in place which ensured that staff were aware of and were following the governance procedures.

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 practice manager. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. Staff told us they enjoyed their work and thought they worked in a mutually supportive team. All staff had received a documented appraisal in the last 12 months.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control, clinical record keeping, antibiotic prescribing and X-ray quality. We found that audits were not analysed in terms of percentages so that results could be compared year on year. Although audit results suggested good levels of compliance there was little evidence of audit results being fed back to dentists for learning purposes. We raised these findings with the practice manager for consideration to improving the auditing processes.

Staff were 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 the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered patient feedback from patient surveys. Actions had been taken as a result. For example, providing evening opening hours, which dentists told us were proving very popular with patients.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team. The practice manager told us staff had raised suggestions on improving services, which had been acted upon. A recent example was in improving the flow of patients waiting to be seen by reception staff whilst dentists completed writing up their clinical notes through the dentists sending a short instant message to the reception after a consultation summarising the

No action

Are services well-led?

consultation. This had resulted in a reduction in queues at the reception desk of patients waiting to check in whilst other patients who had been seen were booking re-appointments or paying for treatment.