Dental Care Falmer

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Inspection Report

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

At a previous inspection in September 2015 we found that there were shortfalls in a number of areas of the clinical governance systems of the practice. We carried out an announced responsive comprehensive inspection on 16 May 2016 to check that these shortfalls had been addressed and 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?

Summary of findings

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

Dental Care Falmer is a general dental practice which is situated within the campus of Sussex University in Falmer, East Sussex. The practice offers NHS and private dental treatment to adults and children. The practice has two dental treatment rooms, a decontamination room for the cleaning, sterilising and packing of dental instruments and a waiting area. All areas of the practice are located on the ground floor enabling access for patients with mobility difficulties.

The practice is open Monday to Friday 9.00 to 5.00pm. Dental Care Falmer has one dentist who on the day of our visit was supported by a dental nurse and a receptionist. Other staff included a part-time dental hygienist and a practice manager.

One of the practice owners is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The registered manager is supported in their role by the practice manager.

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 received feedback from 23 patients and an additional three patients on the day of our visit. These provided a positive view of the services the practice provides. Patients commented on the high quality of care provided by the dentists, the friendly nature of all staff and the cleanliness of the practice.

Our key findings were:

- The practice philosophy was to provide friendly patient centred care.
- Staff had been trained to handle emergencies, appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were in place and the practice followed published guidance.
- The practice had a safeguarding lead and processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment as well as urgent and emergency care when required.
- Staff recruitment files contained essential information in relation to Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015.
- Staff had received training appropriate to their roles and were supported in their continued professional development by the practice manager.
- Information from 23 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly and professional service.
- We saw that the practice reviewed and dealt with written complaints according to their practice policy.

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

- Review the availability of hearing loops for patients who are hard of hearing
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Consider the provision of an annual infection prevention control statement in accordance with The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Implement a system of regular appraisals for all staff at the practice.
- Update the practices' details on the NHS Choices website including responding to patient feedback.

Summary of findings

- Consider obtaining support in relation to the practice manager role through professional organisations within the dental sector.
- Review the health and safety risk assessment process so that the risk assessment is personalised to the practice.
- Consider updating the control of substances hazardous to health (COSHH) file.

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 effective arrangements in place for 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 appropriately maintained. The practice took their responsibilities for patient safety seriously. 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 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 where appropriate were registered with the General Dental Council 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 23 completed Care Quality Commission patient comment cards and obtained the views of a further three patients on the day of our visit. 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 dentists were good at explaining the treatment that was 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 when required. The practice had two 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 governance arrangements for this location were overseen by the dentist and the practice manager who were responsible for the day to day running of the practice.

At our last visit we were unable to review multiple documents and records, this included policies, procedures, protocols and certificates because the practice manager was unable to locate them. At this visit we were able to review these documents, records and certificates.

Summary of findings

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. We found staff to be hard working, caring and committed to the work they did.

We found there were a number of clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality.

The practice gathered feedback from patients mainly through the Family and Friends test and their own system that was based on the Family and Friends test format. Although improvements to the systems could be made.

Dental Care Falmer

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 16 May 2016 was led by a CQC inspector who had remote specialist advice from 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 including proof of registration with their professional bodies.

During the inspection, we spoke with the practice manager, dentist, an agency dental nurse who is regularly used by the practice and the receptionist. We reviewed policies, procedures and other documents. We also obtained the views of three patients on the day of our visit. We reviewed 23 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 manager described an awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were no incidents during 2016 that required investigation.

Reliable safety systems and processes (including safeguarding)

We spoke to the dental nurse 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. A practice policy was in place that reflected the requirements of the directive. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special needle guard to prevent the occurrence of contaminated needle stick injuries as far as possible. A practice protocol was in place and understood by staff should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We asked the dentist how the practice treated the use of instruments used during root canal treatment. They explained that these instruments were single use only. They also 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). We saw evidence of a rubber dam kit in the practice. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. When rubber dam was not used the dentist used other safety measures to prevent inhalation or swallowing of root canal instruments.

The practice manager now acted as the safeguarding lead and 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 or neglect. Since our last visit training records were available that showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. 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 in recent times.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. There was an automated external defibrillator,(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). We noted that the warning light of the AED showed that the battery was iin need of replacement. The practice manager informed us that a new battery had been ordred and the practice was awaiting delivery. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. This included oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen were all in date and stored in a central location known to all staff. The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled staff to replace out of date medicines and equipment promptly. We saw from records in staff recruitment files that staff had received update training in dealing with medical emergencies during 2015-16.

Staff recruitment

At our last visit we were unable to review the recruitment files of staff members. At this visit we saw evidence that staff had checks made prior to recruitment these included proof of identity, immunisation status, proof of current registration with the General Dental Council, professional indeminity and immunisation records for Hepatitis B. 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

Are services safe?

they may have contact with children or adults who may be vulnerable. 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.

Monitoring health & safety and responding to risks

At our previous visit there were a number of shortfalls in monitoring and mitigating health and safety risks. At this visit we found that these areas had been addressed. For example a new fire risk assessment had been undertaken in February 2016 had been undertaken. Fire safety signs were clearly displayed, fire extinguishers had been recently serviced and staff demonstrated to us how to respond in the event of a fire. We also saw that a Legionella risk assessment had been carried out in November 2015. We did note that there were other areas where improvements could be made, this included a refresh of the control of substances hazardous to health file (COSHH). A more comprehensive file should be maintained to reflect all of the hazardous substances used in the practice.

Infection control

At our previous visit we found that there were shortfalls with respect to infection prevention control processes. At this visit we found that all of these shortfalls had been rectified. There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed and the practice. This was demonstrated through direct observation of the cleaning process and a review of practice protocols that showed HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We observed that audits of infection control processes carried out in May 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the two dental treatment rooms, waiting area and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. This included the working surfaces; dental unit and dental chair were decontaminated. They also explained how the dental water lines were maintained. The dental unit 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. We saw that a Legionella risk assessment had been carried out in November 2015 at the practice by a competent person. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifier instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, they were pouched and stored until required. Pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. We observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always 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. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste. We also saw that general environmental cleaning was carried out by the dental nurse working at the practice and they carried out cleaning according to a cleaning plan developed by the practice. Cleaning materials were stored in a separate storage facility.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave was serviced and calibrated in March 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in March 2016 and with documentation showing that this was valid until March 2019. Portable appliance testing had been carried out in February 2016 and an electrical safety certificate had been carried out and was valid until March 2017. 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. We found that the practice stored prescription pads securely to prevent loss due to theft. We observed 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 documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000. We noted 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 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 a series of radiological audits was available for inspection. These audits were undertaken during March and December 2015 and March 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with demonstrated they carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that 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 oral cancer. Patients were 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 tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we saw 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 tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The dentist we spoke with was very 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. The dentist 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 or prescribed high concentration fluoride tooth paste. 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 where applicable. They gave advice on tooth brushing techniques explained to patients 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.

Staffing

Dental Care Falmer has one dentist who on the day of our visit was supported by a dental nurse and a receptionist. Other staff include a part-time dental hygienist and a practice manager. The practice manager explained that a agency dental nurse was used to cover a member of staff on maternity leave. The nurse on duty worked at the practice on a regular basis. The patients we spoke with on the day of our visit said they had confidence and trust in the dentist. This was also reflected in the Care Quality Commission comment cards we observed. We observed a friendly atmosphere at the practice. Staff told us they felt they had acquired the necessary skills to carry out their role.

We were told the dental hygienist worked without chairside support. We drew to the attention of the practice manager the advice given in the General Dental Council's Standard (6.2.2) for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

We spoke with the dentist about how they implemented the principles of informed consent; they had a clear understanding of consent issues. 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. They went on to say that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options.

We spoke to the dentist about 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 went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the 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 is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. 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.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 23 completed CQC patient comment cards and obtained the views of three patients on the day of our visit. These provided a positive view of the service the practice provided. Patients commented that the quality of care was very good, 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. During the inspection, we observed staff in the reception area and found that they were polite and helpful towards patients. The general atmosphere of the practice was welcoming and friendly.

Involvement in decisions about care and treatment

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw that the practice waiting area displayed a variety of information. This included opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. On the day of our visit we observed that the appointment diaries although busy, were not unduly overbooked. This provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentist 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 made reasonable adjustments to help prevent inequity for patients that experience limited mobility or other issues that hamper them from accessing services. To improve access the practice had level access and treatment rooms on the ground floor for those patients with a range of disabilities and infirmity as well as parents and carers using prams and pushchairs. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

Access to the service

The practice is open Monday to Friday 9.00 to 5.00pm. 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, on the outside of the practice and on the telephone answering machine when the practice was closed.

Concerns & complaints

On our previous visit we found that there were shortfalls in the way complaints and concerns were handled by the practice. At this visit we found that the practice procedure for acknowledging, recording, investigating and responding to complaints had been implemented when we reviewed a written complaint made by a patient in April 2016. 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.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location were overseen by the dentist and the practice manager who were responsible for the day to day running of the practice. The practice manager was relatively new to the dental sector.The practice manager wanted to run an efficient practice but we felt that they would benefit from obtaining peer support to deliver on these aspirations. At our last visit we were unable to review multiple documents and records, this included policies, procedures, protocols and certificates because the practice manager was unable to locate them. At this visit we were able to review these documents and records. We noted that practice system of policies and procedures were maintained in two policy files and were kept under review. Policies were all reviewed during the period September/October 2015.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a good understanding of the principles of clinical governance in dentistry, were generally happy with the practice facilities. Staff we spoke with were motivated and enjoyed working at the practice.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. There was evidence of repeat audits at appropriate intervals for X-ray quality and these reflected that standards were being maintained.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training was completed through a variety of resources including the attendance at lectures and online courses. Recruitment records of the dentist, dental hygienist, agency dental nurse, practice manager and receptionist all reflected this.

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

The practice gathered feedback from patients mainly through the Family and Friends test and their own system that was based on the Family and Friends test format. The results we saw showed patients were satisfied with the care provided by the practice. We did note that although a brief analysis was documented, a more robust analysis of patients feedback would provide more meaningful data about how patients view the practice. The practice would then be better placed to introduce improvements to the practice as a result of feedback. We also noted that the NHS Choices website had not been updated for sometime and responses to patient comments were not made. A permanent member of staff told us they felt valued and were proud to be part of the team. They also told us they felt included in the running of the practice and how the practice management team listened to their opinions.