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Teethinline - Newport Pagnell

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 January 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

Teethinline – Newport Pagnell is an orthodontic referral practice located in the centre of Newport Pagnell it offers NHS and private orthodontic treatments to adults and children. The practice share premises, staff and policies with a general dental service Newport Pagnell Dental Clinic.

The service is located on the ground floor of a commercial building, with reception, three treatment rooms and the main waiting room, separated from a further two treatment rooms and a waiting room, by a hall way that provides access to a separate business within the same building. Across the two services; four general dentists, three orthodontists, a hygienist and an orthodontist therapist work with support of 12 dental nurses, three treatment coordinators and six administration and reception staff.

The principal orthodontist 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.

Summary of findings

25 people provided feedback about the service. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Feedback was overwhelmingly positive about the service.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice made excellent use of dental nurses with extended competencies, supporting them in their training, and encouraging them to further their careers.
- Governance arrangements were in place for the smooth running of the practice.
- Patient feedback indicated that patients were treated with kindness, dignity and respect.
- Staff recruitment checks had been carried out in accordance with schedule three of the Health and Social Care Act 2008. Disclosure and barring service checks had been carried out on all staff to ensure the practice employed fit and proper persons.
- The practice carried out weekly treatment session inspections, where all aspects of the clinical work was observed and feedback given to the clinicians.
- The practice used an outside company which contacts patients after appointments by way of a text message or e-mail and invites a comment about the service.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the frequency of obtaining a written medical history to reduce the risk of changes being missed that may impact on treatment.
- Review the practice's audit processes and document learning so that resulting improvements can be demonstrated.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

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.

New staff were recruited in accordance with the recommendations of schedule 3 of the Health and Social Care Act 2008.

Infection control was found to meet the essential requirements set out in the Department of Health document 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.

Equipment was found to be serviced and maintained in accordance with manufacturer's guidelines.

Ten of the dental nurses had achieved their certificate in dental radiography and were able to take X-rays. The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000.

The practice carried out regular medical emergencies training with an external trainer visiting the practice. In addition they undertook regular scenario based training with in the practice team.

However we found the provider did not have all necessary equipment to deal with medical emergencies in the event of an emergency occurring. The missing equipment was highlighted and ordered by the practice during the inspection.

Are services effective?

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

All clinical staff were registered with the General Dental Council, and were fulfilling the requirements of their professional registration.

We found the practice was keeping comprehensive and accurate dental care records.

Staff demonstrated good knowledge of the process of consent, and all patients were provided with a written treatment plan. The practice orthodontists were able to explain in detail the principles of allowing a child to consent for themselves with reference to the legal precedent of Gillick competence.

Are services caring?

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

Confidentiality was maintained by way of a password protected computer system. The practice kept no paper dental care records.

Patients reported that staff always treated them with care and respect, patients felt involved in decisions about care and treatment needs.

Are services responsive to people's needs?

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

Dental nurses with training in oral health promotion visited local schools and youth groups to promote good oral health.

Complaints were thoroughly investigated in a timely manner and appropriate actions taken.

Summary of findings

Are services well-led?

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

The practice had maintenance schedules in place for essential equipment to comply with manufacturers' instructions.

Staff were supported to obtain further training and qualifications.

Regular staff meetings ensured that communication between this large and well-motivated team remained a high priority.

Teethinline - Newport Pagnell

Detailed findings

Background to this inspection

The inspection was carried out on 5 January 2016 by a CQC inspector and a dental specialist advisor.

We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the the principal orthodontist (who was the registered manager) the practice manager, dental nurses and the reception team. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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?

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Significant incidents were logged and investigated by the practice manager; we saw examples of feedback from staff being investigated as a significant event, which resulted in a change of policy and clarification to all staff. There was evidence of discussion of significant events in the regular team meetings.

The practice was moving over to a system whereby a proforma could be filled in which detailed the incident, as well as the outcomes and learning. This would improve the effectiveness of learning from incidents.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) these were e-mailed to the practice and the practice manager would disseminate relevant alerts to the staff by e-mail.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager informed us of how they would make such a report.

The practice had an accident book, which detailed accidents to patients and staff. Although actions were noted there was no obvious feedback or learning from these accidents. We discussed this with the practice manager who agreed that in future these should be treated as significant events.

Reliable safety systems and processes (including safeguarding)

The practice had a policy regarding safeguarding of vulnerable adults, and child protection. For ease of access, all policies were stored on the computer system, and could be accessed by any member of staff via any of the terminals in the building. The safeguarding folder on the computer included referral forms, as well as a flow chart and guidance for reporting concerns. In addition there were useful contact numbers on a poster in the staff area for staff to refer to.

Staff we spoke with were all aware of when and how to raise a safeguarding concern, and were able to identify the safeguarding lead within the practice. All staff had received training in safeguarding appropriate to their role.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 1 October 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Medical emergencies

The practice carried emergency medicines in line with those detailed in the British National Formulary (BNF). However, although the practice carried adrenaline, in the form of a pre-filled syringe, it was only enough to administer one or two doses. The BNF states that in the event of a severe allergic reaction adrenaline may need to be administered every five minutes. Following our inspection we have received evidence that more adrenaline has been ordered to cover such an eventuality.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The battery and pads were checked regularly to ensure that this would function correctly if required. Records were seen pertaining to these checks.

The practice had other emergency equipment as outlined in the Resuscitation Council UK guidance, with the exception of portable suction and a suction tip for the portable suction. These could be required in the event of a medical emergency to clear vomit and secretions from the airway. Following our inspection these items have now been purchased.

Emergency equipment was checked and logged daily and robust procedures noted to ensure all emergency medicines and equipment were re-ordered before they expired.

All staff undertook annual medical emergencies training with an external provider who visited the practice. In addition they had regular scenario training whereby a member of staff would pretend to be having a medical emergency and staff would have to respond to their needs.

Staff we spoke with had a good understanding of how to deal with a range of medical emergencies which may occur in the dental practice.

Staff recruitment

Are services safe?

We looked at the staff recruitment files for five staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was 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 found that the recruitment procedures had been followed in accordance with schedule 3 of the Health and Social Care Act. DBS checks had been carried out on all members of staff in accordance with their own recruitment procedure.

An induction process was carried out for every new member of staff; this introduced new members of staff to the policies and procedures in the practice. It took place over several weeks and a checklist was available to ensure that new staff had covered the essential practice information. New starters were appraised four weeks after joining and again at 12 weeks to ensure that their training and development needs were being met.

Monitoring health & safety and responding to risks

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place and available for all staff to access via the shared computer drive. In addition a health and safety checklist was an integral part of the induction process; this drew attention to all the main risks of the environment.

The practice had a fire evacuation policy, and fire extinguishers were serviced every year. In addition an internal fire risk assessment had been carried out by a staff member designated as fire warden. However that responsibility of obtaining an external fire risk assessment, and servicing the fire alarms lay with a separate business within the same building. The practice manager was able to obtain evidence of these during our inspection, and upon discussion understood that they have to maintain oversight of these in order to ensure the safety of patients, staff and visitors to the practice.

Staff we spoke with had a good understanding of their role in the event of a fire, and regular fire drills were carried out.

There were adequate arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy in place which had been reviewed in September 2015. This detailed aspects of infection control and directed staff to other, more specific documentation regarding decontamination of dental instruments. Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again.

The practice did not have a separate decontamination room, therefore washing and sterilising of dental instruments was carried out in the treatment rooms. However the practice is exploring options to acquire a decontamination room.

We observed staff undertaking the decontamination process by way of manually cleaning and then autoclaving the instruments. This was in accordance with HTM 01-05 essential requirements. However HTM 01-05 recommends the use of an illuminated magnifier to check for visible debris remaining on the instruments following manual washing; however the magnifiers that the practice were using were not illuminated. We also discussed with the practice their use of lined trays for instruments. Currently they disinfect them between uses, but said they would consider sterilising them.

Are services safe?

Autoclaves were used to sterilise the instruments and checks were made daily to ensure effective working. These checks were robust, and in accordance with the guidance.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice were checking the mains water temperatures, flushing and disinfecting the water lines. An assessment of risk had been carried out by an external assessor, and the practice policy was in line with the recommendations of this assessment.

In addition the practice carried out regular water checking by sending samples to an appropriate company for analysis. In response to this they had received a certificate that indicated the quality of the water was maintained.

All clinical staff had documented immunity against Hepatitis B. Staff 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 the risk of contracting blood borne infections.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out the full range of dental procedures that they offered.

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Pressure vessel testing had been carried out on the autoclaves and compressor to ensure they functioned safely.

The practice kept a stock of antibiotics, these were in date, and stored appropriately. Records were kept of the dispensing of these medicines.

Prescriptions were issued singly by the practice manager so pads were not left in treatment rooms.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000.

All treatment rooms displayed the 'local rules' of the X-ray machine on the wall. These are specific documents to each X-ray set detailing (amongst other things) the designated Radiation Protection Advisor, and Radiation Protection Supervisor. Schematics were available that detail the direction of the X-ray beam and area of possible scatter (the tiny amount of radiation that can spread outside the beam area.

A radiation protection folder demonstrated regular testing and servicing of the equipment most recently in March 2015, as well as a full inventory of equipment, and a list of dental nurses that had been trained to process the X-rays. In total 18 clinicians (dentists, dental hygienists and dental nurses) had received the appropriate training to take X-rays.

The practice used exclusively digital X-rays, which are available to be viewed almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

Justification for taking an X-ray was documented in the patients dental care record, as well as a report of the findings of the radiograph.

The quality of the X-ray image was logged and audited every three months so that the overall quality of X-rays could be monitored. In this way the effective dose of radiation to the patients was as low as reasonably possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

Three orthodontists worked at the service. The orthodontists that we spoke with demonstrated a thorough understanding of the national guidelines available to aid diagnosis and treatment.

The orthodontists we spoke with were familiar with, and guided by the recommendations of the British Orthodontic Society in their practice.

The orthodontists we spoke with were aware of the risks of orthodontic treatment in regard to precipitating problems with gum health and decalcification of enamel around orthodontic brackets. This is the earliest stage of dental decay and can be caused by fixed orthodontic appliances making effective cleaning difficult. If these early signs are missed it can progress to dental disease that is irreversible.

It was demonstrated through the dental care records that we were shown that the dentists were keeping accurate records of the patients' oral health, as well as discussions that had taken place regarding their treatment, the reasons for taking X-rays and the findings of the X-rays.

Medical history forms were filled in and signed by the patients every two years. In the intervening period the medical history was only verbally checked. It was felt that this was not sufficiently robust to pick up any changes in the patients' medical history that may impact on treatment.

Health promotion & prevention

The practice promoted the maintenance of good oral health, and had trained three dental nurses in oral health so that they were able to work independently, advising on oral hygiene and oral health matters.

Orthodontic patients were given oral hygiene instruction prior to treatment starting, which could be re-visited if standards were not being maintained. Orthodontic patients could be referred to the dental hygienist is further treatment and oral health advice was required.

These trained dental nurses had also provided oral health talks to several local schools and youth groups, and one of the team was awarded a dental charity award for 'promoting a positive message about dentistry to patients and the community'.

Smoking cessation leaflets were available, dental care records demonstrated that smoking and alcohol advice was being given. In addition staff were aware of all the local smoking cessation services available that patients could be referred to should they wish.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice demonstrated appropriate staffing levels, and skill mix to deliver the treatments offered to the patients.

There was excellent support of the dental nurses in obtaining extended competency training. 10 dental nurses had completed the training to take radiographs, three had completed the certificate in oral health education course, and others were trained to take impression moulds. In addition three dental nurses had assumed the role of treatment co-ordinators, giving patients one on one time to discuss treatment plans and concerns away for the treatment room.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control, radiology and fire awareness training.

Working with other services

As a referral practice themselves, referral to any other service would usually be done through the patient's own

Are services effective?

(for example, treatment is effective)

general dental practitioner. They did however refer to a hygienist in the event of oral hygiene not being maintained, and would provide the dental hygienist with a written prescription for treatment to be carried out.

Consent to care and treatment

It was clear through discussions with the clinicians and dental care records seen that consent is considered a multi-stage process. This would involve clinical discussions with patients, and giving patients the opportunity to consider and then re-consider their options before a decision is reached. Orthodontic patients were provided with a comprehensive written treatment plan.

The practice used treatment co-ordinators to confirm understanding and consent. A dedicated space and time is set aside for patients to discuss all aspects of their treatment plan, away from the treatment room itself. The experience of these treatment co-ordinators is that patients are more likely to ask questions in this less intimidating environment, and find it easier to open up about their concerns.

The Mental Capacity Act 2005 (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. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent, understanding that capacity should be assumed even if the patient has a condition which may affect their mental capacity, and when it may be necessary to make decisions in a patient's best interests.

There was good understanding of situations in which a child (under 16 years old) may be able to consent for themselves rather than relying on a parent to consent for them. This is termed Gillick competence and depends on the child's understanding of the procedure and the consequences in having/ not having the treatment. The Orthodontists had relied on this legal framework to guide them on more than one occasion in the past.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with explained how they ensured that patient details were kept confidential. In the treatment rooms computers were password protected and staff would log off before leaving the room. It was noted at the reception desk that computers were positioned so that patients at the desk could not see details on the screen. The practice had no paper records for patients, any paper generated (for example medical history forms) were scanned into the computer and immediately destroyed.

Staff had undertaken training in data protection, IT security and confidentiality and this was underpinned by an information governance policy.

We observed staff interacting with patients throughout the inspections, and in all cases, found that they interacted with patients in a friendly, professional and discreet manner, which was highlighted through the patient feedback we received.

Involvement in decisions about care and treatment

Patient feedback that we received reported that they felt fully involved in decisions about their care; many opportunities were afforded them to discuss their treatment and costs involved.

Treatment co-ordinators offered a further opportunity to discuss treatment. With dedicated time and space away from the treatment room, all aspects of their proposed treatment could be discussed with themselves and their family and concerns addressed.

Discussions with patients were recorded in the dental care records, although not always comprehensively.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs.

The practice had installed a self-check in system, so that orthodontic patients who had attended the practice before did not have to wait at the desk to speak with a receptionist. The practice had also installed a wireless network in the waiting room so patients were able to access the internet whilst they waited for their appointment.

The practice used treatment co-ordinators to offer patients an opportunity to talk through their treatment needs and options as part of the consent process. In addition they talked to nervous patients to understand how their needs can be met, and to show both young patients, and nervous patients around the practice to familiarise them with the premises.

Tackling inequity and promoting equality

We spoke with staff about ways in which they interacted with patients with differing communication needs. In the case of patients for whom English was not their first language, they would first consult their colleagues as some were multi-lingual. In addition the practice subscribed to a telephone translation service, which staff could utilise should it prove necessary.

Staff also described how their practice had altered in the treating of patients who were hard of hearing. This included particular reference to sitting in front of the patient and removing face masks so that the patients were able to lip read.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. This was available on the shared computer drive which could be accessed from any of the terminals.

Access to the service

The practice had disabled access through a rear entrance to the premises. Staff also explained that a car could be bought up to the door at this entrance so that patients of limited mobility would not have far to walk.

Emergency appointments were set aside, and patients commented that although they could not always be seen quickly for a routine appointment, they could always be seen if it was an emergency.

The practice was open from 8.30 am to 5.30 pm Monday to Thursday, and 8.30 am to 4.30 pm on a Friday. We received feedback from patients which commented on the usefulness of the early appointments for working patients and those with other commitments during normal working hours.

Patients were directed to the NHS emergency out of hours number (111) if they had an urgent problem outside normal practice hours. This was directly linked via the telephone system, or directed from the website.

Concerns & complaints

The practice had a complaints policy which was available for patients to view in the patient information folder in the waiting room.

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.

We saw evidence that apologies were issued to patients appropriately, and complaints were discussed at regular team meetings.

Are services well-led?

Our findings

Governance arrangements

The practice had in place a principal dentist and a principal orthodontist, a practice manager and a lead dental nurse; nonetheless staff reported clear lines of responsibility and accountability, which had been clarified recently with the introduction of a new policy document. In addition the practice principals had reviewed and integrated themselves further within the governance arrangements of the practice.

The practice had policies and procedures in place to support the management of the service, and these were available on the shared drive of the computer system for the staff to reference. These included a complaints policy, safeguarding, and infection control policies.

A maintenance schedule was in place to ensure that essential equipment was serviced in a timely manner. Risk assessments were in place to identify and minimise risks to staff and visitors to the practice including fire safety, pregnancy and Control of Substances Hazardous to Health.

Half day staff meetings were carried out every six weeks, and less formal 'lunch and learn' meetings in between.

We asked to see evidence that all staff were up to date with their radiology training. The practice manager reported that they were, but did not keep copies of their certification. Following the inspection documentation was sent pertaining to all staff that take radiographs in the practice.

Leadership, openness and transparency

Staff reported an open and honest working environment, where opinions of all staff were taken into account, and staff were actively encouraged to raise any concerns that they had.

Discussions with the practice principal demonstrated a clear understanding of staff need, well-being and care.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Staff were actively encouraged and supported to undertake training; with almost all of the dental nurses have at least one extended competency. This seemed to contribute to high levels of motivation that were reported by staff.

Staff underwent regular appraisals in order to identify their training needs and wishes, as a result of these a personal development plan was drawn up, which could be followed.

The practice bought in external trainers during team meetings, covering multiple topics including medical emergencies, mental capacity act and infection control. Most recently the practice had an afternoon exploring the practice values and ethos.

Regular clinical audit was carried out on a range of topics including X-ray quality (three monthly), infection control (six monthly) and record keeping (yearly). Although these audits were through, the inspection team felt that they would be more effective if they were clinician specific rather than overall so that areas for improvement could be more easily identified and acted upon.

In addition to the audits the practice operated a rolling system of surgery inspections. The lead dental nurse would sit in on each treatment room for half a day per week, making notes on all aspects of the practice, from decontamination to the interactions between patients and clinicians. These were all recorded at the results discussed with the staff. In this way the practice was constantly striving to improve its practice.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. There was a comments box, and comments form for patients to complete in the waiting room. In addition they were collecting information via the NHS friends and family scheme.

When the practice found it was not getting much feedback through either of these sources they contracted a company that specialises in collecting data after appointments. Patients are contacted by text message or e-mail and invited to reply with a comment about their recent treatment. The yield of comments from this has been significant and has helped the practice streamline its procedures.

Are services well-led?

Staff were encouraged to give feedback either formally or informally. Examples were given where staff feedback has effected change. In one instance staff requested a uniform change, and in another instance it was raised that with multiple people in management positions staff were not always clear who to talk to for specific concerns. This concern was placed into the agenda at the next staff meeting, where a discussion with all staff yielded the results which were then placed into policy for all staff to refer to.