We carried out an announced comprehensive inspection of RAF Leeming Dental Centre on 6 June 2017.

To get to the heart of patient's experience of care and treatment we asked 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 formed the framework for the areas we looked at during the inspection.

**Our findings were:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Action Required</th>
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<tr>
<td>Are services safe?</td>
<td>Improvements required</td>
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<tr>
<td>Are services effective?</td>
<td>No action required</td>
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<tr>
<td>Are services caring?</td>
<td>No action required</td>
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<tr>
<td>Are services responsive?</td>
<td>No action required</td>
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<tr>
<td>Are services well-led?</td>
<td>No action required</td>
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Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

This inspection was led by a CQC inspector and supported by a CQC inspection manager and a military dental specialist advisor.

Background to this practice

RAF Leeming Dental Centre was providing a service to a population of 1400. The centre has three surgeries which accommodate one full time military dentist, a part-time civilian dentist, a part-time dental hygienist and a visiting orthodontist who was providing a service at the practice one day every three weeks. The full time military practice manager was deployed on operations and one of the dental nurses was acting in the role of practice manager. A part time dental nurse was in post, and two locum dental nurses were providing cover at the time of our inspection. The dental centre was co-located with the Department of Community Mental Health and could support access for people with limited mobility.

How we carried out this inspection

Prior to the inspection we reviewed information about the practice provided to CQC by the DMS.

On the day of inspection we collected 35 CQC comment cards filled in by patients and spoke with three other patients. This information gave us a positive view of the practice.

During the inspection we spoke with the acting practice manager and another practice manager who was providing support, the senior dental officer, a dentist, orthodontist and dental nurse. We looked at practice systems, policies, standard operating procedures and other records in relation to how the service was managed. We also checked the building, equipment and facilities.

Our key findings were:

- The environment was clean and equipment was well maintained.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems for recording incidents, accidents and significant events.
- The practice had systems to support the management of risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and young people.
- Staff were appropriately recruited and received a comprehensive induction when they started work at the practice.
• The clinical staff provided care and treatment in line with current guidelines.
• Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
• The appointment system met patient’s needs.
• The practice had effective leadership. Staff felt involved and supported, and worked well as a team.
• The practice asked patients for feedback about the services they provided.
• The practice had an effective system in place to deal with complaints.

We found areas where the practice could make improvements. CQC recommends that the practice:

• A review of the infrastructure and facilities used for the decontamination of dental equipment 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’.
• A review the arrangements for fire safety in the building taking into account fire safety regulations.
• A review of the current staffing resource and skill mix to ensure it is adequate to meet the needs of the population.

Dr John Milne MBE BChD, Senior National Dental Advisor (on behalf of CQC’s Chief Inspector of Primary Medical Services)
Our findings

We found that this practice was not safe in accordance with CQC's inspection framework

The shortcomings did not have a significant impact on the safety and quality of clinical care.

Reporting, learning and improvement from incidents

Underpinned by policy and procedure, the practice used the standardised DMS-wide electronic system to report, investigate and learn from significant events, incidents and near misses. Staff were aware of their role in the reporting and managing of incidents, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice was informed by regional headquarters about the outcome of investigations into incidents and significant events in other dental practices. The acting practice manager provided examples of the learning and action taken in response to significant events and incidents, including an example of the action taken following the failure of X-ray equipment.

The practice manager received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). Relevant alerts were discussed practice meetings.

Reliable safety systems and processes (including safeguarding)

The senior dental officer (SDO) was the safeguarding lead for the practice. Staff knew their responsibilities if they had concerns about the safety of adults who were vulnerable due to their circumstances. A safeguarding policy and procedure was in place to provide staff with information about identifying, reporting and dealing with suspected abuse.

The safeguarding procedure was available in a prominent place for staff to quickly access. We were provided with evidence to confirm staff received safeguarding training at a level relevant to their role. The practice manager said the training was refreshed every three years. The practice had never had cause to report a safeguarding concern.

The practice manager confirmed that the dentists always treated patients with the support of a dental nurse. The hygienist did not have another member of staff in the surgery while treating
patients. A risk was assessment was in place to support this arrangement. We noted it did not take account of the action to take in the event of a medical emergency. The practice manager revised the risk assessment and forwarded it to us shortly after the inspection.

A whistleblowing policy was in place. Staff were aware of how to report a concern in accordance with the policy and said they felt confident they could raise concerns without fear of recrimination.

We looked at the practice’s arrangements for safe dental care and treatment. These included risk assessments that were regularly reviewed. The practice followed relevant safety laws when using needles and other sharp dental items. The dentists routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society.

A business continuity policy and disaster recovery plan was in place, which set out how the service would be provided if an incident occurred that impacted on its operation.

**Medical emergencies**

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every six months. Training was provided at the regional training days and involved simulated training scenarios. The practice manager also coordinated periodic training within the dental centre. A record of this training was logged and the practice manager monitored it to ensure staff attendance.

Emergency equipment and medicines, including oxygen were available as described in recognised guidance. Staff kept records of the daily checks they undertook to ensure the required equipment and medicines were available, within their expiry date and that equipment was in working order.

Bodily fluids and mercury spillage kits were available, along with a first aid kit. The practice manager confirmed that the staff team had received first aid training.

**Staff recruitment**

The full range of recruitment records were held centrally at the regional headquarters. The practice manager had access to the DMS-wide electronic system so could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service check to ensure staff were suitable to work with vulnerable adults and young people. The system also monitored each member of staff’s registration status with the General Dental Council (GDC). The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

We looked at the recruitment record for a temporary member of staff recently recruited through an agency. It included all the relevant checks and confirmation that the member of staff had their own indemnity.

The practice was not meeting one of the dental targets set by the military. This target is in relation to service personnel requiring either an annual dental assessment or who have an undetermined dental status because they have either no or an incomplete dental record. We noted a clear decline in meeting the target each month from March 2017. From our discussions with staff we determined this decline was influenced by a number of factors.

Turbulence to the staff team was identified by staff as one of the factors. Since March 2017 key
staff had transferred, were absent or had been deployed, including the temporary loss of the practice manager. One of the nurses was acting into the practice manager role and locum nurses were providing cover for the staff gaps. Cover was also being provided in an emergency from other local military dental centres. Staff said locum staff were not familiar with the electronic systems so were not in a position to carry out a large part of the administration that nurses routinely engaged with. This included monitoring and following up on patient recalls; a key activity to ensure patients receive an appointment. This activity is also closely linked to meeting the target the practice was currently not meeting. Furthermore, failure to attend appointments for May 2017 had increased by 2% from March 2017 as patients were not routinely receiving reminders in advance of their appointment.

Providing support at a satellite dental practice was also another factor staff identified. Since January 2017 the team, comprising a dentist and two other staff, were providing dental treatment at the satellite practice on a needs basis. We looked at the staffing rotas and noted on average satellite support was provided three full days a month (four days in March 2017). Staff said since this arrangement had been put in place the dental targets at the satellite clinic had improved but deteriorated at Leeming Dental Centre. We concluded that the practice did not have sufficient staff with the required skills to meet the population need.

**Monitoring health & safety and responding to risks**

Organisation-wide health and safety policy and protocols were in place to support with managing potential risk. Records demonstrated that staff were up-to-date with health and safety training. The practice manager who was deployed had been the health and safety officer for the practice and had completed the required health and safety course for the role. Although the SDO had not completed this course, they had taken on this role in the short term absence of the practice manager.

The station’s Safety, Health, Environment and Fire (SHEF) department was responsible for ensuring routine health and safety risk assessments of the premises. Evidence was in place showing a health and safety audit was carried out in December 2016 and a workplace place inspection was undertaken in April 2017. The practice manager also carried out their own checks of the premises, including a check of all areas each morning to ensure the premises were safe. They said maintenance requests were dealt with in a timely way and any health and safety concerns were responded to promptly.

The SHEF department was responsible for the management of fire systems and a fire management plan was in place for the station. A fire risk assessment of the premises had been undertaken in February 2015.

Records showed that staff were up-to-date with fire training. The practice manager said that a fire evacuation exercise had not taken place for some time. Given the recent increase in the use of locum staff who may not be fully familiar with the fire procedures, the practice manager said they would arrange for an evacuation practice to take place as soon as possible.

During the inspection we observed doors, including at least one fire door, retained in the open position using door wedges. We highlighted to the practice manager that this is not in accordance with fire regulations. Wedging fire doors in the open position means the escape routes are not protected, placing people’s safety at risk in the event of a fire. The practice manager said they would discuss with the SHEF department alternative ‘hold open’ devices for fire doors. A Control of Substances Hazardous to Health (COSHH) file was maintained electronically for the station to ensure information on the risks from hazardous substances was available for staff. Risk
assessments for each of the COSHH products were in place along with safety data sheets; information sheets about each hazardous product, including handling, storage and emergency measures in case of an accident. We had been informed that locum staff were not familiar with the electronic systems so we queried how they would access the COSHH risk assessments in a timely way if the need arose. The practice manager said they would ensure hard-copies of the risk assessments for the clinical COSHH products used at the practice were made available.

**Infection control**

An infection prevention and control (IPC) policy supported by protocols was in place at the practice. It followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. One of the dental nurses was the dedicated lead for IPC and had completed relevant training for the role. The staff team were up-to-date with IPC training and records confirmed staff completed IPC training as part of their continuing professional development. IPC updates were provided at the biannual regional training days. Staff also received updates at practice team meetings.

The facilities for undertaking decontamination of dental instruments were not suitable and not in accordance with HTM 01-05. Part of the decontamination process was undertaken in the surgeries and part in a recently identified decontamination room. The surgeries had designated clean and dirty areas and a separate handwashing sink. Instruments were cleaned in the surgeries and then transported to the decontamination room for sterilisation. We noted that the sinks in both areas were fitted with overflows, which is not in accordance with current guidance.

The decontamination room had not been refurbished to meet HTM 01-05. There was just one sink and no handwashing sink. There were holes in the walls, the flooring was ripped in places and the ventilation was not adequate. The practice manager advised us that a request for refurbishment of the decontamination room had been submitted to regional headquarters two months ago but they had not received any confirmation as to what action would be taken.

The dental nurse demonstrated the decontamination process for us, including the cleaning, checking, sterilising and storing of instruments. Instruments were appropriately and safely sterilised particularly given the limitations of the infrastructure to support the process. Records showed the equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturer’s guidance. IPC audits were completed twice a year. We looked at the audit from April 2017 and it identified the concerns with the decontamination facilities.

Although a Legionella risk assessment could not be made available on the day of inspection, staff informed us it had been completed, including a management plan to reduce the possibility of Legionella or other bacteria developing in the water systems. An external contractor carried out monthly safety checks of the relevant hot and cold water outlets each month. Six monthly water quality checks were also undertaken.

Environmental cleaning was carried out by an external company twice a day. The practice was clean when we inspected and patient’s feedback did not highlight any concerns with the cleanliness of the practice. Environmental cleaning equipment was in accordance with national guidance, including how it was stored.

Arrangements were in place for the segregation, secure storage and disposal of clinical waste products, including amalgam, extracted teeth and gypsum.
Equipment and medicines

Equipment logs were maintained by the practice manager that kept a track of when equipment was due to be serviced. An equipment service audit was undertaken in April 2016. Staff carried out routine equipment checks in line with the manufacturer’s recommendations. A safety test of portable electrical appliances had been undertaken in August 2016.

The practice had suitable systems for the safe management of medicines as described in current guidance. Prescription sheets were stored securely. Antibiotics were logged, checked and stored appropriately. Medicines requiring cold storage were refrigerated and the temperature of the fridge was monitored and recorded each day.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The practice was meeting current radiation regulations and had the required information in the radiation protection file. Local Rules were located in the radiation file and also alongside the X-ray machine they related to. A critical examination of the X-ray machines was undertaken in January 2017.

The dental records we looked at showed that the dentists justified, graded and reported on the X-rays they took. In accordance with current guidance and legislation, the practice carried out X-ray audits on a quarterly basis. Clinical staff were up-to-date with dental radiography training and they had completed it as part of their continuous professional development.
Our findings

We found that this practice was effective in accordance with CQC's inspection framework

Monitoring and improving outcomes for patients

We looked at eight dental records completed by two dentists. They were detailed, containing comprehensive information about the patient’s current dental needs, past treatment, medical history and treatment options. The diagnosis and treatment plan for each patient was clearly recorded and showed that treatment options were discussed with the patient. The dentist assessed patient’s treatment needs in line with recognised guidance. For example, the dentist followed appropriate guidance in relation to the management of wisdom teeth and recall intervals between oral health reviews.

Feedback from patients indicated that their dental assessment and treatment was thorough, and they found it beneficial to be briefed about what was happening at of every stage of the treatment process.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Dental records showed that oral hygiene advice was given to patients on an individual basis, including discussions about lifestyle habits. Referrals could be made to other health professionals, such as referrals for advice about smoking and alcohol use. The application of fluoride varnish was an option the dental professionals considered if necessary but advised us that is was not often used now given the population age.

An oral health promotion stand was located in the waiting area and this was refreshed on a regular basis to include promotion of new topics, such as Smile Month, Stoptober and Mouth Cancer Awareness Week. Staff said the dental team participated in the regular health and wellbeing promotion fairs held at the station.

Staffing

Staff new to the practice had a period of induction based on a structured induction programme. The induction records for a locum member of staff demonstrated a comprehensive process that took account of matters such as, health and safety, radiation, fire, complaints, IPC and operational systems.

We looked at the organisational-wide electronic system that recorded and monitored staff training and appraisal. Through this we confirmed staff were up-to-date with the training they were required to complete. The training included safeguarding, equality and diversity, workplace safety,
business continuity, IPC, medical emergencies and information governance. Furthermore, the
system showed clinical staff were undertaking the continuous professional development required
for their registration with the General Dental Council.

**Working with other services**

Staff confirmed patients could be referred to a range of services if the treatment required was not
provided at the practice. These services included referrals to military enhanced dental practices
(practices providing additional services, such as sedation) and external referrals to a local NHS
trust for oral surgery. A referral protocol was in place for suspected oral cancer under the national
two week wait arrangements. This was initiated in 2005 by The National Institute for Health and
Care Excellence (NICE) to help make sure patients were seen quickly by a specialist.

The practice manager maintained a log of all referrals made and monitored the status of these on
a regular basis, particularly to ensure urgent referrals were dealt with promptly.

**Consent to care and treatment**

Staff we spoke with understood the importance of obtaining and recording patient’s consent to
treatment. They said they gave patients information about treatment options and the risks and
benefits of these so they could make informed decisions. The dental records we looked at
confirmed this. Verbal consent was taken from patients for routine treatment. For more complex
procedures, full written consent was obtained. Feedback informed us that patients were satisfied
that they received clear information about their treatment and treatment options were discussed
with them.

Staff had a good understanding of their responsibilities under the Mental Capacity Act (2005)
should they need to treat adults who may not be able to make informed decisions. Staff said they
had recently received training in consent.
Our findings

We found that this practice was caring in accordance with CQC's inspection framework

Respect, dignity, compassion and empathy

Staff we spoke with were aware of their responsibility to respect people’s diversity and human rights. Patients commented favourably about the practice in their feedback. They said staff were professional, attentive and friendly. They suggested the communication was good and the explanation of treatment being provided was valuable.

Patient’s feedback indicated staff were understanding and put them at ease if they were nervous about having dental treatment. A range of strategies were used to support with reducing anxiety. These included an extended appointment time, referral for cognitive behavioural therapy or hypnotherapy at the co-located Department of Community Mental Health. Patients could also be referred to an enhanced practice for conscious sedation.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas did not fully provide privacy when reception staff were liaising with patients. Staff said if a patient required more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it. Staff password protected patient’s electronic care records and backed these up to secure storage. Paper records were stored securely at the practice.

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed in the patient waiting area and available in the practice leaflet.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to help with making treatment choices. The dental records clearly showed patients were informed about the treatment choices available and were involved in the decision making. Oral health information leaflets were available for patients.
Our findings

We found that this practice was responsive in accordance with CQC's inspection framework

Responding to and meeting patients’ needs

Patient feedback suggested high levels of satisfaction with the responsive service provided by the practice, including urgent out-of-hours access.

The practice had a routine appointment system to respond to patient need. Staff followed the principle that all regular serving military personnel were required to have a periodic dental inspection every 6 - 24 months depending on a dental risk assessment or recall period. The practice manager said they conducted regular searches on the dental electronic patient record system to check that patients had an appointment with the dentist in accordance with their recall time. There was a three to four week wait for routine appointments.

Staff usually made contact with patients the day before to remind them of their appointment. This process had slipped over the last three months due to a shortage of staff familiar with the system. As a result there had been an increase in failed attendance at appointments.

Promoting equality

An access audit as defined in the Equality Act 2010 was not available for the premises. This audit forms the basis of a plan to support with improving accessibility of premises, facilities and service for patients, staff and others with a disability. Although the population of wheelchair users and patients with disabilities was very low, reasonable adjustments were in place. For example, there was step-free access to the building and an accessible toilet was available at the medical centre located close by.

A hearing loop was not available as this had not been identified as a need for the population at the station. Staff had access to a translation service should the need arise. Patients could choose the gender of their dentist if they had a preference.

Access to the service

The practice displayed its opening hours in the premises. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. They were aware of how to access the out-of-hours dental services.

Time was allocated for emergencies (referred to as sick parade) in the morning. A rota was in place for access to an on-call dentist out-of-hours. This rota was available at the guardroom and was also held by heads of department.
**Concerns and complaints**

The senior dental officer was responsible for managing complaints. A complaints policy and protocol was in place that provided guidance for staff on how to handle a complaint. Staff had received training in complaints so were familiar with the policy and their responsibilities. Processes were in place for documenting and managing complaints. The practice manager confirmed that no complaints had been received the last 12 months.
Our findings

We found that this practice was well-led in accordance with CQC's inspection framework

Governance arrangements

The senior dental officer had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. At the time of the inspection the full time practice manager had been deployed since April 2017 and was due to return to post in September 2017. As an interim arrangement, one of the nurses was acting into the role of practice manager. This was their first practice manager role so they were being supported and mentored by a practice manager from another military dental centre.

Through discussions with staff, we were provided with an overview of the governance arrangements for the dental centre, including lines of reporting and accountability. The practice manager provided a report to regional headquarters (RHQ) each month that reported on a range of clinical and non-clinical statistics and activity. The Common Assurance Framework (CAF), a structured self-assessment internal quality assurance process, formed the basis for monitoring the quality of the service. The practice manager in collaboration with the dental team completed the CAF and the practice manager kept it under review and updated it as appropriate.

We were provided with a copy of the most recent CAF prior to the inspection. It showed a compliance of 33% for the practice. Taking into account our inspection findings and evidence we were presented with, we worked through the CAF with the practice manager and reached a compliance score of 93%. We discussed with the practice manager whether the CAF was out-of-date due to recent staff turbulence, a decline in the continuity of administrative support and other operational priorities.

The Principal Dental officer (PDO) for the region had access to the CAF and carried out unannounced spot checks. Using the CAF framework, the PDO coordinated a bi-annual health governance assurance audit of the dental centre. If required an action plan was developed following this and was then updated by the by the practice manager as actions were completed. It was accessible on the system for the PDO to monitor. We asked to see the action plan following the last health governance assurance audit in March 2015. We were advised this had not been completed due to staff changes.

A framework of organisation-wide policies, procedures and protocols were in place. In addition, there were dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff were familiar with these and they made reference to them throughout the inspection. Risk management processes were in place to ensure the safety of patients and staff working at the dental centre. They included risk assessments relating to clinical practice, the environment, equipment and lone working. A range of checks and audits were in place to monitor the quality of service provision.
The practice manager provided an overview of the dental centre’s relationships and engagement at station level. Meetings were held, such as unit committee meetings to discuss matters, including the dental fitness of the population, infrastructure, maintenance, equipment and staffing. Attendance at these meetings had not been consistent recently due to staff turbulence. For the same reason practice meetings had not been taking place routinely every month. A practice meeting had taken place the week prior to our inspection.

We looked at communication systems within the practice. The main forum for sharing information was through the monthly practice meetings. We looked at previous meeting minutes and noted they included standard agenda items, such as equipment, SHEF, governance, significant incidents, staff training and complaints. The outcome of investigations, audit and other quality checks was shared with the staff team. MHRA and CAS alerts were also discussed at the meetings. The practice manager provided feedback to the staff team from the various meetings they attended.

Information governance arrangements were established and staff were aware of the importance of these in protecting patient’s personal information. Each member of staff had their login password to access the electronic systems. They were not permitted to share their passwords with other staff. Paper records were stored securely.

**Leadership, openness and transparency**

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff said the culture was open and transparent, and they would be confident raising any concerns. They told us they were treated with respect at all levels of the organisation and felt any concerns they may raise would be listened to and acted on appropriately. It was evident from observation and discussions that the team valued each other’s contribution and worked well together. The practice manager said that even with the recent staff turbulence the team supported each other.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. These included a programme of audit. IPC audits were conducted every six months. The IPC audit identified the concerns with the facilities for decontamination. The dentist completed a radiology audit every six months. Other audits undertaken included a complaints audit and a recall audit. The outcome of the recall of patients audit showed the practice was below target at 30%. Staff said this was linked to the loss of administrative support, in particular the reduction in staff that can competently use the system. A method of delivering local anaesthetic audit exceeded the target with an outcome of 97%. A dental records audit was in progress at the time of the inspection.

The practice had records of the results of these audits, including the action plans and improvements made. For example, the way local anaesthesia was recorded in dental records was amended as a result of the audit.

Staff received mid and end year annual appraisal. We saw evidence of completed appraisals. The system showed appraisals were out of date by approximately four weeks. The practice manager provided a valid reason for this with assurance that they would be completed shortly.
The staff said they participated in a peer review every year with other dental professionals within region. This was a two day event with the first day for military staff and the second day for all staff.

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

A process was in place to seek patient feedback. We looked at the last survey and noted the feedback received about the practice was positive. A suggestion box was located in the waiting area. The practice manager said four suggestions had been made in the last month. It was all positive feedback rather than suggestions for improvement.

A system was in place for staff to provide feedback and this was organised through the Defence Medical Services.