We carried out an announced comprehensive inspection of HMS Neptune Dental Centre on 5 December 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:**

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<thead>
<tr>
<th>Are services safe?</th>
<th>No action required</th>
<th>✓</th>
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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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<td>Are services responsive?</td>
<td>No action required</td>
<td>✓</td>
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<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 specialist military dental officer advisor.

Background to this practice

HMS Neptune Dental Centre is a six chair practice providing a routine dental service to a population of 6700. Royal Navy personnel and Royal Marines make up 3300 of the population and the remaining 3400 work on the base. Providing a routine dental service, the practice places a strong emphasis on prevention particularly as deployed submariners have no access to dental care. Facilities include a central sterilisation department and five X-ray units.

The dental centre is open Monday to Thursday from 08:00 to 12:00 and 13:00 to 17:00. It is open on Friday from 08:00 to 12:30. The practice provides an emergency service and extended opening hours to meet patient need. Led by a senior dental surgeon, the team of military and civilian staff included a deputy senior dental surgeon, two civilian dentists, five dental nurses and a dental hygienist. The clinical team was supported by a practice manager, practice supervisor and two receptionists.

Patients can be referred internally and to the local NHS Trust for treatment not provided at the dental centre. Arrangements are in place for access to an emergency dental service outside of working hours.

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice manager.

During the inspection we spoke with the practice manager, practice supervisor, the senior dental surgeon, deputy senior dental surgeon, two dentists, two dental nurses and two reception staff. 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.

On the day of inspection we collected 34 CQC comment cards completed by patients prior to the inspection. We also spoke with four patients who were attending the dental centre for an appointment. All the feedback from patients was positive, including their experience of treatment and care at the practice.

Our key findings were:

- The practice used a DMS-wide electronic system for reporting and managing incidents,
We identified the following notable practice, which had a positive impact on patient experience:

Leadership of the practice was focused on making quality improvements. A whole team approach was embedded as staff continually sought to improve clinical effectiveness and develop an efficient service. The following evidence supports this:

Communication within the practice and with base commanders was robust. Regular meetings were held with unit commanders to monitor dental fitness and failed attendance at appointments.

Practice meetings for the whole staff team were held weekly; the format of the meetings was highly structured ensuring priority topics in relation to high risk areas were discussed each week and other required topics had a slot for discussion at a practice meeting during the month.

The practice was engaged in quality improvement initiatives over and above what was expected, including both clinical and non-clinical audits, and the development of a bespoke dental centre community web page via the Defence Gateway. This could be accessed by service personnel at the base and acted as a one stop shop for information about the services offered by the practice.

The practice was very responsive to patient feedback about the service. At the time of the inspection extended working hours were being piloted in response to patient feedback about providing more flexible opening times. This meant staff changing their working hours to meet patient need.

We found areas where the practice could make improvements. CQC recommends:
Given the layout and size of the premises, and in the absence of a functioning alarm system, the practice should review the timeliness of staff response in the event of an incident or medical emergency.

Dr John Milne MBE BChD, Senior National Dental Advisor
(on behalf of CQC’s Chief Inspector of Primary Medical Services)
Are services safe?

Our findings

We found that this practice was safe in accordance with CQC’s inspection framework

Reporting, learning and improvement from incidents

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events, incidents and near misses. All staff had access to the system to report a significant event. Staff were clear in their understanding of the types of significant events that should be reported and understood how to report an incident, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff received refresher training in significant events every six months.

The practice manager clarified that locum staff completed a hardcopy significant event form which was then uploaded by the practice manager to the system. Once they had worked at the practice for over three months they were provided with electronic access to the ASER system.

Examples of significant events reported in the last 12 months related to the use of equipment. The practice manager described the action taken which successfully minimised the reoccurrence of similar events. Significant events were a core agenda item for discussion at the weekly practice meetings.

The practice manager was informed by Regional Headquarters (RHQ) about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Department of Health Central Alerting System (CAS). The MHRA and CAS alerts received were logged and saved. As a core agenda item, they were discussed at the weekly practice meetings.

Reliable safety systems and processes (including safeguarding)

The senior dental surgeon (SDS) was the safeguarding lead for the practice and had completed level 3 safeguarding training. The remainder of the staff team had completed training at a level appropriate to their role. Training was refreshed every three years. Staff we spoke with were aware of their responsibilities if they had concerns about the safety of young people and 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. It included local contact numbers.

The practice had not had to manage a safeguarding concern. It did not treat children and at the time of the inspection there were no vulnerable adults registered. Staff highlighted that there was a potential for patients aged 16 to 18 to be treated at the practice. The dentists were always supported by a dental nurse when assessing and treating patients.

The hygienist did not have the support of a nurse when treating patients. Although there was a panic alarm in the treatment rooms to summon assistance in the event of a medical emergency, it was not in working order at the time of our inspection. We were advised that the system had been deactivated some time ago. The practice manager said they would report this and request the panic alarm system be re-activated. Shortly after the inspection the SDS forwarded to us a risk assessment outlining the arrangements for lone working in the context of a potential medical emergency.

A whistleblowing policy was in place and available to staff. Staff accurately described what they would do if they wished to report in accordance with the policy. They 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 dentist routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society. They also used a rubber dam for some other complex treatments, such as restorative work.

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**

A member of staff was identified as the lead for medical emergencies. Records showed staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED (automated external defibrillator). This training was refreshed every six months. Annual simulated emergency scenarios took place at the practice and records were in place for indicating the staff that participated. Daily checks of the medical emergency kits were recorded and demonstrated that all items were present and in-date.

The two emergency kits that were located in the corridor during working hours and then locked away when the practice was closed were in accordance with recognised guidance. The controlled drugs (medicines with a potential for abuse or addiction) used in the event of a medical emergency were stored with the emergency kit in the corridor. This was not safe practice and shortly after the inspection we received an email from the SDS confirming the medical emergency kits had been moved to surgeries that could be locked when unoccupied. A risk assessment was also developed outlining in detail the measures in place to ensure the safety of controlled drugs.

Bodily fluids and mercury spillage kits were available in each surgery. A first aid kit was available also. Training records confirmed staff were up-to-date with first aid training.

**Staff recruitment**

The full range of recruitment records for permanent staff was held centrally. 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 (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.

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.

There were sufficient staff to provide a safe, timely and good quality service to patients. Feedback from patients and staff indicated patients secured an appointment when they needed it with no delays. Although there were two receptionists at the time of the inspection, one was temporary and due to leave. Staff said the practice would benefit from an additional receptionist/administrator as it was a very busy due to the size of the patient population.

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

Organisation-wide health and safety policy and protocols were in place to support with managing potential risk. These, along with local health and safety information were displayed on a notice board. The practice manager was the lead for health and safety and had received relevant training for the role. There was a building manager for the base who the practice manager described as very responsive to any concerns in relation to the premises. A health and safety audit of the environment was undertaken in November 2017 and it took account of matters such as, fire, risk assessments and COSHH (Control of Substances Hazardous to Health).

A wide range of risk assessments were in place for the practice, including assessments for the environment, personal protective equipment, sharps injuries and water safety. Records demonstrated that staff were up-to-date with health and safety training. Training was provided at induction and through on-line courses.

The management of fire systems at the practice was undertaken by the Defence Fire Service located at the base; a full fire risk assessment for the building was undertaken in April 2016 and fire safety checks of equipment were undertaken annually. Weekly and monthly tests of the fire system and firefighting equipment were in place. Staff received annual fire training and the building manager coordinated an annual evacuation drill; the most recent drill took place in November 2017.

The SDS and practice manager were the leads for the management of COSHH. The practice manager undertook an annual review of the COSHH products used at the practice. The last review was undertaken in November 2017. COSHH risk assessments and product data sheets were available for staff to reference. Product data sheets provide information about each hazardous product, including handling, storage and emergency measures in case of an accident.

**Infection control**

An Infection prevention and control (IPC) folder was located in the CSSD (central sterile services department) and in all surgeries. It included the IPC policy and supporting protocols, which took account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) 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. Staff were up-to-date with IPC training and records confirmed they completed refresher IPC training every six months.
Decontamination of dental instruments took place in the CSSD, which was arranged and organised to support the safe decontamination of dental instruments. We observed a sterilisation cycle and noted a clear flow from dirty to clean areas. Sterilisation was undertaken in accordance with HTM 01-05. Routine checks were in place to monitor that the ultrasonic bath and autoclave were working correctly.

The surgeries, including fixtures and fittings, were tidy, clean and clutter free. Clean and dirty areas were clearly labelled and were used correctly by staff. Instruments and materials were checked regularly; we noted that they were appropriately stored and all were within their sterilisation use-by-date. IPC audits were undertaken twice a year by the IPC lead. They were stored in the IPC folder and electronically. The outcomes of the audits were shared with the staff team at the practice meetings. Water lines were well managed at the practice. They were flushed in accordance with guidance and the water quality checked daily with a test kit. In addition, water was tested every six months to ensure it was safe.

A legionella risk assessment had been carried out for the base. The legionella management arrangements were laid out in a policy document that identified the responsible persons for the management of legionella and described monitoring arrangements of water systems. The building manager was responsible for monitoring the temperatures of the sentinel taps (nearest and furthest water outlets from both the hot and cold water supply). Records showed that these checks were carried out weekly. We looked at the records for November and the temperature of sentinel taps were within the expected temperature range.

Environmental cleaning was carried out by a contracted company twice a day. The practice was clean when we inspected and patient feedback did not highlight any concerns with the cleanliness. Environmental cleaning equipment was used and stored in accordance with national guidance. Arrangements were in place for the segregation, secure storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth and gypsum. Clinical waste was collected weekly or more frequently if required. Consignment notes were in place and a clinical waste log maintained.

**Equipment and medicines**

Routine equipment checks in accordance with the manufacturer’s recommendations were undertaken. Records showed the clinical equipment had all been serviced within the last 12 months. 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 annually. Safety tests of portable electrical appliances were up-to-date.

Medicines that required cold storage were kept in a fridge, the temperature of which was checked daily to ensure it was within the correct parameters. Prescription sheets were stored securely but not logged to monitor their use. Shortly after the inspection the SDS provided evidence to demonstrate that a register had been developed that included the serial numbers of prescriptions.

**Radiography (X-rays)**

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were displayed in each surgery, along with safety procedures for radiography. Evidence was in place to show equipment was maintained every three years.
To corroborate our findings we looked at range of patient’s dental records. They showed the dentist justified, graded and reported on the radiographs they took. In accordance with current guidance and legislation, the dentist carried out radiograph audits every six months. We were advised that at the next audit dentists would audit each other’s radiographs. 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 the dental records for six patients to corroborate our findings. The records were detailed; containing comprehensive information about each patients’ 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. Patients completed a detailed medical and dental history form and this was verbally checked for any changes at each subsequent appointment. With the consent of the patient, we observed a dental examination and found it was thorough.

Patients’ treatment needs were assessed by the dentist in line with recognised guidance. For example, treatment was planned in accordance with the BPE (basic periodontal examination - assessment of the gums) and caries (tooth decay) risk assessment. The dentist also followed appropriate guidance in relation to the management of wisdom teeth and recall intervals between oral health reviews. When deployed, submariners do not have access to dental treatment therefore recall periods were monitored closely, with any extensions to recalls avoided. Feedback from patients indicated that the assessment and treatment they received was thorough.

Health promotion & prevention

Because submariners do not have access to dental care when deployed, prevention was a key objective of the practice. Therefore, a proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health. This was undertaken in line with the Delivering Better Oral Health toolkit. Dental records showed that lifestyle habits of patients, such as smoking and drinking, were included in the dental assessment process. An alcohol consumption audit was completed with all patients. Oral hygiene advice was given to patients on an individual basis, including discussions about lifestyle habits. The application of fluoride varnish and the use of fissure sealants were options the clinicians considered if necessary. Equally, high concentration fluoride toothpaste was recommended where appropriate. Referrals could be made to other health professionals, such as referrals to a medical centre for advice about smoking, diet and alcohol use. Although patients were receiving care in accordance with their need, the enhanced skills of dental nurses (oral health education, application of fluoride varnish) were not being utilised to their maximum due to staffing constraints.

Oral health displays were evident in the patient waiting area. Staff said the displays were refreshed on a regular basis and they often targeted population need and/or seasonal activities, such as Stoptober. The practice supported other oral health promotion campaigns, including Smile Week and Mouth Cancer Awareness Week. The dental team participated in the health and wellbeing promotion fairs held at the station.
The deputy senior dental surgeon (DSDS) attended monthly meetings with the submarine command to provide updates on the military dental targets and review the status of failed attendance at dental appointments (referred to as FTAs). A report on the status of FTAs was submitted each week to the base warrant officer. In addition, the senior dental surgeon (SDS) attended meetings with the Captain of the base and other heads of departments to discuss wider and more strategic issues, including the risk register.

**Staffing**

Staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. We spoke with a member of staff who had recently transferred to the team. They described a detailed induction programme when they first started that took account of areas, such as health and safety, fire, complaints, IPC and operational systems. New staff also received guidance and training in how to use the electronic patient record system.

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. The system showed clinical staff were undertaking the continuing professional development (CPD) required for their registration with the General Dental Council. The practice also had its own ‘in-house’ training programme and staff could suggest topics to include in this. With the consent of staff, we looked at two CPD files. They showed that staff regularly kept up to date with their CPD requirements.

**Working with other services**

The practice could refer patients to a range of services if the treatment required was not provided at the practice. These services included referrals to enhanced military dental practices (practices providing additional services, such as endodontics) and external referrals to a local NHS trust for oral surgery. Staff were aware of the referral protocol 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. One of the dentists maintained a referral log and the dental nurses checked this weekly to ensure urgent referrals were dealt with promptly. If needed they followed up on any referrals that were not progressing in a timely way.

**Consent to care and treatment**

Staff we spoke with understood the importance of obtaining and recording patient 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.

Even though the staff we spoke with had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting, a training need had been identified and this training had been scheduled to take place.
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. Feedback from patients, including the 34 feedback cards completed by patients prior to the inspection, suggested patients were pleased with the way staff treated them. Emerging themes suggested staff were professional, respectful and provided an honest and understandable explanation of each stage of their treatment plan.

Patient feedback also indicated staff were understanding and put them at ease if they felt nervous about having dental treatment. If a patient was anxious about receiving dental treatment then it was discussed at their appointment. Patients were offered the opportunity to make a longer appointment and talk through their anxiety if appropriate. If necessary other strategies for reducing anxiety could be considered, such as referral to the mental health team, medication pre-treatment or, as a final option referral, to an enhanced practice for conscious sedation. The dentists said they had not needed to refer any anxious patients for treatment under sedation.

The environment was large enough to support effective privacy and confidentiality, particularly in the waiting area as the reception was a distance from the seating. 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 in locked metal cabinets.

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 support with making treatment choices. The dental records clearly showed patients were informed about the treatment choices available and were involved in decision making. A range of oral health information and leaflets were available for patients and a wide range of this information was accessible to patients in the waiting area.
Are services responsive to people’s needs?
(for example, to feedback?)

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 a high level of satisfaction regarding the responsiveness of the practice, including access to a dentist for an urgent assessment and emergencies out-of-hours. The nature of the service required all military personnel to be dentally fit at all times, particularly for submariners who have no access to dental care when deployed. The practice could accommodate block booking requests for whole units to ensure their dental fitness before deployment.

The practice also took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every six to 24 months depending on a dental risk assessment and rating for each patient. Recalls were regularly scrutinised along with FTAs. The practice manager and practice supervisor said they used every resource to contact patients who had missed an appointment or were due a check-up. A log of recalls was maintained and this was checked regularly. Patients could make routine appointments between their recall periods if they had any changes to or concerns about their oral health.

At the time of the inspection the practice was piloting extended working hours. This was in response to patient feedback about providing more flexible opening times. It meant the practice was open until 18:00 Monday to Thursday and closed to routine dentistry on a Friday. Three staff were available at the practice each Friday for emergencies; a dentist, nurse and administrator. The pilot was in its infancy so it was too early to determine the impact it was having in relation to the individual patient and population need.

Promoting equality

An up-to-date 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 services for patients, staff and others with a disability. Although the population of wheelchair users and patients with physical disabilities was very low, the practice manager confirmed that patients who could not use the stairs had access to the practice via a lift. Automatic door opening and an accessible toilet further supported the experience for wheelchair users. 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 this be required. Because of the skill and gender mix within the team, patients could request to be treated by a dentist of a specific gender.

Access to the service

The opening hours of the practice were displayed in the premises, recorded on the answer phone message and available in the practice leaflet. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. Appointment slots were kept
free for patients with pain or an urgent dental need; patients were always seen within 12 hours. On-call arrangements, in agreement with the local NHS emergency dental service, were in place for access to a dentist outside of working hours.

Concerns and complaints

The senior dental surgeon (SDS) was overall responsible for complaints. The practice manager had the delegated responsibility for managing the complaints process. A complaints procedure was displayed in the waiting area for patients and summarised in the practice leaflet.

Staff had received training in complaints so were familiar with the policy and their responsibilities. Processes were in place for documenting and managing complaints. A process was in place for managing complaints, including a complaints register. One complaint had been received in the last 12 months and we could see from the records that it been effectively managed in accordance with procedure.
Are services well-led?

Our findings

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

Governance arrangements

The senior dental surgeon (SDS) had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for the day to day running of the service. All staff were accountable to the SDS.

The practice manager provided an overview of the governance arrangements for the dental centre. An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance of military primary health care services, including dentistry. The CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by practices to assure the standards of health care delivery within DMS. When a CAF review is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV was undertaken in October 2015.

A report was sent to regional headquarters (RHQ) each month that reported on a range of clinical and non-clinical statistics and activity at the practice. For example, the report included an update on the status of the practice’s performance against the military dental targets, complaints received and significant events.

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 and use of equipment. A range of checks and audits were in place to monitor the quality of service provision.

The lines of communication within the practice and with the base chain of command were structured, robust and of value to all parties and at all organisational levels. For example, either the SDS or their deputy attended regular meetings with the Captain of the base, heads of department and unit commanders to discuss service delivery and monitor the dental fitness of military personnel. Dental fitness targets were reviewed along with failed attendance at appointments (FTA). Relevant outcomes from these meetings were shared with staff at the practice meetings.

A team brief was held every Monday to check the workload for the week, ensure sufficient staffing and skill mix, and to check/confirm medical emergency arrangements. The main forum for sharing information was through structured formal practice meetings held every Wednesday; the format of the meetings took into account managerial and clinical matters. Each week core agenda items were discussed including significant events, medical alerts, staff training, complaints and CAF.
Specific agenda items were identified for discussion once a month. For example, the risk register was identified for discussion in week one, audit activity in week two and radiology in week three. We looked at previous meeting minutes and noted they were detailed with actions identified, including who was to complete the action.

Peer review meetings were also established. Dentists met to discuss cases, particularly complex cases and to discuss the progress of clinical audits. Nurses also had their own meetings; they said they valued this opportunity to discuss matters relevant to their role as nurses.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient 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 spoke highly of the leadership at the practice, highlighting that the culture was open and transparent so they would be confident raising any concerns. Staff felt they were part of the team, were treated with respect and consulted about any proposed service developments. It was evident from observation and discussions that the team valued each other’s contribution and worked well together.

Staff were aware of their responsibilities in relation to duty of candour requirements.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. The practice actively sought out audit opportunities to both improve clinical effectiveness and efficiency of the service provided. A programme of audit was in place including: an infection prevention and control audit every six months; radiography audit; FTA audit; an endodontic outcome audit and an instrument processing audit to determine the effectiveness of the ultrasonic cleaners. Audits also took place in relation to complaints and equipment.

In response to monitoring appointment trends, feedback from patients and the introduction of flexible working hours, the practice was piloting and auditing a four-day week (Monday to Thursday) service with extended working hours until 18:00 hours. Sufficient staff were available on Fridays for emergencies and the day was also used to undertake audit and administrative duties. Staff said they were pleased with this arrangement as it was meeting their needs. The trend had shown that not many patients booked Friday appointments so this day was being used more efficiently for non-clinical activities. Again seeking to improve efficiency, the practice was also undertaking an audit of hardcopy records, in particular to determine the frequency in which dental staff needed access to these records. Both of these audits were ongoing and the intention was to share the results with the chain of command.

The staff team attended a regional training day three times a year, where they received training updates and had an opportunity to participate in clinical peer review. Staff received mid and end of year annual appraisal. We saw from the staff monitoring system that staff appraisals were up-to-date.

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

A centralised process had been in place to seek patient feedback but the practice manager
advised us the survey had stopped whilst it was under review. A new survey process was about to be introduced. A suggestion box was located in the waiting area and the practice manager monitored it on a regular basis.

A system was in place for staff to provide feedback to the Surgeon General each year. The appraisal process also encouraged staff to give feedback on the service.