Overall summary

We carried out an announced comprehensive inspection of Topcliffe Dental Centre on 16 November 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>Question</th>
<th>Action Required</th>
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<tr>
<td>Are services safe?</td>
<td>No action required</td>
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<tr>
<td>Are services effective?</td>
<td>No action required</td>
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<td>Are services caring?</td>
<td>No action required</td>
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<td>Are services responsive?</td>
<td>No action required</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 two specialist military dental advisors, a dental officer and a practice manager.

Background to this practice

Topcliffe Dental Centre is a two chair practice. One chair is routinely used by the dental team and the remaining chair is used by visiting dental practitioners, such as the principal dental officer and a visiting hygienist. Routine dentistry is provided at the dental centre. Patients can be referred internally and to the local NHS Trust for treatment not provided at the dental centre. The practice has two X-ray sets and decontamination of dental instruments is undertaken in a dedicated room.

The dental centre is open from 07:45 to 16:30 Monday to Thursday and closes from 12:30 to 13:30 for lunch. On a Friday the centre either opens from 07:45 to 13:15 or 07:30 to 15:45 depending on need. It is closed at the weekend. Arrangements are in place for access to an emergency dental service outside of working hours.

At the time of the inspection the staff team were all civilians and consisted of a senior dental officer, a practice manager and two dental nurses.

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, the senior dental officer, and the two dental nurses. 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 40 CQC comment cards completed by patients prior to the inspection. We also spoke with three 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, accidents and significant events.
- Systems were in place to support the management of risk, including clinical and non-clinical
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 together as a team.
- The practice had an effective system in place to deal with complaints.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- Systems for assessing, monitoring and improving the quality of the service were in place.
- The decontamination room did not have a handwashing sink.
- Documentation was not available to demonstrate that infection prevention and control audits were taking place every six months.
- Formal practice meetings were not held frequently enough and the meeting agenda did not include all the required agenda items.
- One of the fire exits did not open and close effectively.
- The sharp system was not being used correctly.
- Not all staff were aware of the principles of the Mental Capacity Act (2005).

The Chief Inspector recommends:

- Review the arrangements for fire safety in the building taking into account fire safety regulations.
- Review the 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’.
- Review the sharp system to ensure it is used correctly and safely.
- Review how infection prevention and control is monitored at the practice, ensuring that audit documentation is available on request.
- Review the arrangements for practice meetings and how they are recorded.
- Review staff understanding and awareness of the Mental Capacity Act (2005).

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 safe in accordance with CQC’s inspection framework

Reporting, learning and improvement from incidents

The practice manager was the lead for significant events. The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events, incidents and near misses. Staff had a clear 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). The locum nurse did not have access to the ASER system and said they would report any incidents to the practice manager who would process the concern through the system.

Three significant events had been reported from 2014 to 2015 but none had been reported since. Staff were clear that there had been no reportable incidents since. We noted from the minutes that significant events were a standard agenda item. Minutes of the practice meeting held on 7 November confirmed this. The minutes also identified that staff had recently received annual refresher training regarding significant events.

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 emailed to staff. Staff said alerts were discussed at practice meetings. They provided examples of two alerts received and discussed at the practice. We noted the standard agenda for practice meetings did not specifically identify alerts as a standard agenda item. The practice manager said they would revise the agenda going forward.

Reliable safety systems and processes (including safeguarding)

The senior dental officer was the safeguarding lead for the practice. Staff 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. A briefing on the safeguarding arrangements was displayed in the waiting area for patients and it included local contact numbers.

The safeguarding procedure was accessible to staff. We were provided with evidence to confirm staff received both child and adult safeguarding training at a level relevant to their role.
Safeguarding training was refreshed every three years. 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 at the practice. Staff were aware of the potential for patients aged 16 to 18 to be treated at the practice.

The dentist was always supported by a dental nurse when assessing and treating patients. The practice manager said that if chairside support was not available for the dentist then the patient clinic would be cancelled. Nurse support was available for the visiting dental professionals.

A whistleblowing policy was in place and available in the staff room. 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 used a ‘Safer Sharp system’ to manage the disposal of needles. This was not being used correctly as it was not secured to the work surface meaning there was a risk to staff sustaining a sharps injury. The opening dates on the safe sharp system and clinical sharps bins were not all accurate, and sharps boxes had not been closed after three months in accordance with recognised guidance.

The dentist routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society. The dentist also used rubber dams for routine restorative procedures.

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**

The emergency medical kit was kept in the corridor between the doors to the waiting area and the surgery. Tamper proof seals were used on the kit, which included the emergency equipment, medicines and oxygen as described in recognised guidance. A risk assessment had not been undertaken given that the kit was stored in an accessible area. Staff said patients were escorted to the surgery by a nurse so would not have access the area on their own. The practice manager completed a risk assessment for the storage arrangements of the emergency medicines during the inspection.

Clear signage was in place denoting the location of the oxygen alongside the emergency medical kit. A sign was not on the door where the spare oxygen cylinder was kept and the practice manager said they would ensure this was addressed without delay.

The medical emergency kit was checked daily to ensure all items were present and in date. We carried out a check and noted syringes and needles were not in place. Staff confirmed these had been ordered. Staff had completed training in emergency resuscitation and this training was refreshed every six months at the regional training day. They had received training in the use of the defibrillator in May 2017. Training included simulated training scenarios. One of the staff described a recent scenario was based on a patient with epilepsy. An alarm system was installed in each surgery for staff to alert other staff in the event of an emergency.

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 at the RHQ. 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.

We looked at recruitment records for a locum member of staff. Locum staff were required to provide evidence of safety checks and training when they first started and we noted these were in place, along with training the locum staff completed since they started at the practice in May 2017. All the required checks had been undertaken as part of the recruitment process, including a DBS check and vaccination clearance. A GDC registration certificate and evidence of indemnity were in place.

Staff said the staffing levels were adequate and sufficient to meet the needs of the population. There had been an unforeseen delay with a part time hygienist starting at the practice. Staff said this addition of a hygienist to the team would ease the pressure on the dentist. Feedback from patients suggested they received appointments and treatment in a timely and efficient way, which supported the view that the practice was adequately staffed.

Monitoring health & safety and responding to risks

Organisation-wide health and safety policy and protocols were in place to support with managing potential risk. The practice manager was the lead for health and safety and had received relevant training for the role. Risk assessments were in place for the practice, including assessments for slips/trips/falls, personal protective equipment, lone working, 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 Quartermaster for the station. They checked the fire system monthly. Firefighting equipment had been checked in August 2017. A fire risk assessment of the dental centre had been conducted shortly before our inspection and the practice manager had not yet received the report. The two recommendations made were being addressed. We noted that one of the fire exits used by wheelchair users was difficult to open and close. The practice manager said they would report it. We received evidence after the inspection to confirm this had happened. A fire evacuation drill had taken place at the time of the fire risk assessment. Records showed that staff were up-to-date with fire training.

A Control of Substances Hazardous to Health (COSHH) file was maintained for the station to ensure information on the risks from hazardous substances was available for staff. The practice manager had the lead for COSHH and conducted a two yearly review of the COSHH dental products used at the practice. The last review was undertaken in June 2017. COSHH risk assessments and product data sheets were available in hard copy for staff to reference. COSHH data sheets provide information about each hazardous product, including handling, storage and emergency measures in case of an accident.

An area of the building that had accommodated the medical centre was not used for any clinical
care. It was used infrequently for wheelchair access via a fire door, which provided an escape route in the event of a fire. The staff changing facilities were located in this area of the building. Trip hazards were evident in various areas of the corridor where the flooring had lifted. Hazard tape had been placed in these unsafe areas.

**Infection control**

An Infection prevention and control (IPC) policy supported by protocols were in place for the practice and these were located in all the surgeries. They were last reviewed in September 2017 and followed 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 IPC training every six months.

In contrast to some other areas of the premises, the two surgeries had been refurbished to a high standard and in accordance with HTM 01-05. There was a dedicated decontamination room at the practice for the sterilisation of dental instruments. Although the room had not been specifically designed as a central sterilisation unit, the staff had made every effort to ensure it was in accordance with recommended practice. For example, some improvement could be made in relation to the flow from dirty to clean areas. It did not have a hand wash sink which meant staff had to return to one of the closely located surgeries to wash their hands. The practice manager confirmed after the inspection that they had reported the absence of a hand wash sink.

Overall the environment for sterilisation, including fixtures and fittings, supported the safe decontamination of dental instruments. We observed that the sterilisation process 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 were tidy, clean and clutter free. Dental instruments and materials were checked each month. We noted that some dental instruments were out-of-date by approximately two months in both surgeries and this was rectified on the day of the inspection.

Staff told us IPC audits were undertaken twice a year. We were provided with completed audits from August 2017, June 2016 and June 2015. Staff were unable to locate the remaining audits.

Water lines were well managed at the practice as water lines were flushed in accordance with guidance, with specific water sterilisation taking place weekly. In addition, water was tested every six months to ensure it was safe. A legionella risk assessment had been carried out for the dental centre in January 2017. The practice manager advised us the assessment was reviewed every two years. The water temperatures were checked every three months.

Environmental cleaning was carried out by an external 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, extracted teeth and gypsum. The waste contract and consignment notes were retained by the practice manager.
Equipment and medicines

Routine equipment checks in accordance with the manufacturer’s recommendations were undertaken. Records showed that 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. A safety test of portable electrical appliances had been undertaken in 2017. Prescriptions were stored in a locked cabinet in reception.

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. Local Rules were located in each of the surgeries and were signed and dated. Safety procedures for radiography were displayed on notice boards in all surgeries. There was evidence in place to show equipment was maintained every three years. The most recent servicing record was dated July 2017. One of the X-ray sets was installed in 2015 but no record of an acceptance test was available. The practice manager said they would follow this up.

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, all clinicians carried out X-ray audits and this was confirmed by records we looked at. Staff were up-to-date with dental radiography training and they had completed it as part of their continuous professional development. A radiology audit was undertaken annually.
Our findings

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

Monitoring and improving outcomes for patients

To corroborate our findings we looked at range of patients dental records. The records 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.

Patients’ treatment needs were assessed by the dentist in line with recognised guidance. For example, treatment was planned in accordance with the 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. Feedback from patients indicated that their dental assessment and treatment was thorough leading to improved dental fitness.

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 lifestyle habits of patients, such as smoking and drinking, were included in the dental assessment process. 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 if appropriate. Referrals could be made to other health professionals, such as referrals to a medical centre for advice about smoking, diet and alcohol use.

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 Month and Mouth Cancer Awareness Week. The dental team participated in the health and wellbeing promotion fairs held at the station.

Staffing

Staff new to the practice, including locum staff, had a period of induction that included a generic programme and induction tailored to the dental centre. We spoke with a member of staff recently recruited and looked at their records. They showed a comprehensive four week induction programme that took account of matters, such as health and safety, radiation, fire, complaints, IPC and operational systems. The induction involved two weeks shadowing more experienced staff. New staff also received guidance and training in how to use the electronic 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. 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.

The practice manager maintained a log of referrals made and the status of the referrals was monitored to ensure urgent referrals were dealt with promptly. If needed the practice manager followed up referrals with a telephone call or email.

**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.

Not all staff had a full awareness of the Mental Capacity Act (2005) should they need to treat adults who may not be able to make informed decisions. The Senior Dental Officer said they would organise training for the staff team.
Are services caring?

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 40 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, caring and informative.

Patient feedback also indicated staff were understanding and put them at ease if they were nervous about having dental treatment. Anxiety was highlighted on the medical history and discussed at the dental inspection appointment. Patients were offered the opportunity to make a longer appointment and talk through their anxiety. Other strategies for reducing anxiety could be considered, such as referral to the mental health team, medication pre-treatment or a referral to an enhanced practice for conscious sedation.

Staff were aware of the importance of privacy and confidentiality. The waiting area was a sufficient distance from the reception desk so the likelihood of patients being overheard at reception was minimal. Confidentiality was further enhanced by a radio on a low volume in the reception area. 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 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 support them with making treatment choices. The dental records clearly showed patients were informed about the treatment choices available and were involved in the decision making. A wide 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.
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 access to a dentist for an urgent assessment and emergencies out-of-hours. Staff followed 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 or recall period. A log of recalls was maintained by the practice manager 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. The practice could accommodate block bookings if required to meet the needs of a regiment.

Promoting equality

At the time of the inspection, 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 disabilities was very low, some reasonable adjustments had been made. Although a fire exit had been identified for wheelchair access, the door did not open with ease. In addition, two small steps on the inside of the door would prevent this entrance/exit from being used appropriately by a wheelchair user.

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. There was just one dentist so if a patient had a preference to be treated by a dentist of the opposite gender then they could be referred to another local practice.

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. They were aware of how to access the out-of-hours dental services.

Patients with an urgent dental need could be seen between 10:00 and 11:00 each day during ‘sick parade’. If patients had an urgent need outside of that time staff said the practice would find a way to accommodate them so they are seen on the same day. A rota was in place for access to an on-call dentist out-of-hours within the region.
Concerns and complaints

The senior dental officer was overall responsible for complaints. The practice manager managed 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 complaints file had been set up including all the required documentation to process a complaint. The practice manager confirmed that no complaints had been received about the practice in the last two years.
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 had the delegated responsibility for the day to day running of the service. All staff were accountable to the senior dental officer who in turn was accountable to the principle dental officer (PDO) for the region. All staff were aware of their role and responsibility within the practice.

The practice manager provided an overview of the governance arrangements for the dental centre. 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 performance against the military dental targets, complaints received and significant events.

An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The CAF we were provided with had been updated in October 2017 and it identified no significant concerns about the service. An update in the form of a progress report on the CAF and associated action plan was submitted to RHQ each quarter by the practice manager.

When a CAF assessment is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV was undertaken in September 2015 and a number of areas were rated as non-compliant; 32 areas of non-compliance across six domains. From the management action plan (MAP) we could see that improvements had been made as the majority of areas of non-compliance had been actioned effectively.

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 medicines, the environment, equipment and lone working. A range of checks and audits were in place to monitor the quality of service provision.

Lines of communication were well established between the practice and chain of command at station level. The monthly station Unit Health Committee meeting minutes showed that the practice manager attended these on a regular basis.
We looked at communication systems within the practice. The main forum for sharing information was through the practice meetings. Formal minuted meetings were held three monthly and informal meetings took place more regularly. We highlighted to the practice manager that formal minuted meetings were required to take place more frequently than three monthly, and this could mean re-grading the informal meeting to formal ones. We looked at the meeting minutes from November 2017 and noted that they did not follow the standard DPHC meeting agenda as some expected standard agenda items were missing, such as MHRA and CAS alerts. Communication also included the 'first sight folder' located in the staff room and was used to share information. The practice manager attended regional practice manager meetings and shared information from that meeting with the staff team.

Information governance arrangements were established 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 and confirmed the culture was open and transparent, and they would be confident raising any concerns. They said 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. Staff said they felt valued and included in the running of the practice.

Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of the matter. Duty of candour is a set of specific legal requirements that leaders of services must follow when things go wrong with care and treatment. This included ensuring all staff understood the requirement to communicate with patients about notifiable safety incidents.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. A programme of audit and checks were in place including, a radiology audit and infection prevention and control audit. Others included audits in relation to complaints, prescribing and waste management. Improvements had been made as a result of audit. For example, a documents audit led to a change in the way information was transferred between practices; the outcome of which was a reduction in documents being lost. A laboratory work audit was also undertaken. Dental fitness targets were monitored closely each month.

The staff team attended a regional training day twice 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 process had been in place to seek patient feedback but the practice manager advised us the survey process was under review. We did see three feedback forms completed by patients that had been sent through to the practice. This feedback was all positive. 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.