Overall summary

We carried out an announced comprehensive inspection of Dental Centre Tidworth on 23 January 2018.

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>Services Safe?</th>
<th>Improvements required</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvements required</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Effective?</th>
<th>No action required</th>
<th>✔</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services Caring?</th>
<th>No action required</th>
<th>✔</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services Responsive?</th>
<th>No action required</th>
<th>✔</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services Well-led?</th>
<th>Improvements required</th>
<th>✗</th>
</tr>
</thead>
</table>
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 Inspector General’s office.

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

Background to this practice

Located in Jellalabad Barracks, Dental Centre Tidworth serves the largest Army camp in HM Forces. A ten chair practice providing a routine dental service to a military population of around 7500. Dental Centre Tidworth also serves several formation Headquarters and specialist units. The mission statement for the practice aligns with that of DPHC (Defence Primary Health Care) and is to “deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”

The Centre has a mix of military, civil service and temporary health workers (locums). There are 25 posts and an additional three trainee dental nurses being mentored at any one time; a number of staff work part-time. There are five dentists (four work part time), with one part time visiting oral surgeon, one part time Principal Dental Officer, one dental therapist and 11 dental nurses (military and civilian, including three who are training). A practice manager manages the day-to-day running of the practice. The dental centre is open Monday to Thursday from 07.45 to 17.00 and on Fridays from 07.45 to 12.30. The practice provides an emergency service during working hours and when the practice is closed. Patients can be referred internally and to the local NHS Trust for treatment not provided at the dental centre.

How we carried out this inspection

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

During the inspection we spoke with the practice manager, the senior dental officer, two dentists, one dental therapist, four dental nurses, reception and administrative 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 57 CQC comment cards completed by patients prior to and during the inspection. We also spoke with six patients who were attending the dental centre for an appointment. All the feedback from patients was positive, apart from one patient who had found it hard to make an appointment and one patient whose x-rays had been delayed due to faulty equipment.

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 some risks. However we noted some gaps in ensuring that all health and safety risks had been comprehensively assessed.
- Suitable safeguarding processes were established and staff knew their responsibilities for safeguarding adults and young people.
- Staff were appropriately recruited. However staff told us that they had not always received a comprehensive induction when they started work at the practice. Most required training was up-to-date but there were some gaps, notably safeguarding training.
- 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 patients’ needs.
- There was scope to make the practice leadership more effective. Not all staff felt involved and supported and lines of accountability were sometimes unclear.
- The practice asked patients for feedback about the services they provided and made improvements to the service based on the feedback.
- There was a system in place for managing complaints, although verbal complaints were not formally captured and so learning was potentially lost.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- We found that work was needed to ensure that infection control guidelines were being followed and standards met.
- Systems for assessing, monitoring and improving the quality of the service were in place but were not always effective.

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

- Ensure that near misses are reported on the ASER system. Broaden learning from significant events through extended sharing across the practice team.
- In relation to the facilities used for treating patients and for the decontamination of dental equipment, ensure that all staff are following the 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’.
- Ensure that mandatory training has been completed by all relevant staff, including a comprehensive induction course and safeguarding. Provide infection control training for the lead nurse.
- Ensure that lines of accountability are clear to all staff and consider ways to improve staff morale.
- Verbal complaints should be formally reported, investigated and learned from to capture essential learning and improvement.
- Ensure that governance gaps are identified and addressed through comprehensive and embedded systems.
The regional management team should measure the ongoing impact on the stability of Dental Centre Tidworth when 'borrowing' staff from Dental Centre Tidworth to resource other dental sites.

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

Are services safe?

Our findings

We found that this practice was not 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 and incidents. Permanent staff had access to the system to report a significant event, but locums were reliant on permanent staff to report on their behalf. 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). However there was scope to also report near misses as a way to prevent significant events from occurring.

The practice maintained a log of significant events, including the action taken and lessons learnt. The log identified that five significant events had been reported in the last 12 months. Significant events had been discussed at practice team meetings, but not all staff we spoke with were clear on learning that had ensued from the ASER system. There was scope to broaden this learning across the staff team.

The practice manager was informed by Regional Headquarters (RHQ) about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). In addition, the practice manager and their deputy were also signed up to receive the alerts directly. The MHRA and CAS alerts received were logged and saved. As a standard agenda item, they were discussed at practice meetings.

Reliable safety systems and processes (including safeguarding)

The senior dental officer (SDO) was the safeguarding lead for the practice and had completed level two safeguarding training. Some of the staff team had completed online training at a level appropriate to their role, but seven members of staff had not received safeguarding training. 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, but this did not contain the local contact details needed to appropriately signpost staff who needed to raise a concern. Staff told us that they would approach the medical
centre if they identified and needed to report suspected abuse. We noted that the needs of a vulnerable patient had been identified by practice staff and concerns appropriately escalated to Chain of Command.

The dentists were always supported by a dental nurse when assessing and treating patients. Where staffing levels allowed, a staff member would also act as chaperone for the dental hygienist, but this was not always possible. Staff rarely worked alone at the practice due to its size, but there was a lone working policy in place to guide staff who did.

A whistleblowing policy was in place and available to staff. Some staff described what they would do if they wished to report in accordance with the policy, but others were not aware that a policy was in place. Some staff stated that they were not sure who they should go to if they had an issue at work as lines of accountability were insufficiently clear.

We looked at the practice’s arrangements for safe dental care and treatment. These included some risk assessments. However the practice was not always following relevant safety legislation when using needles and other sharp dental items. Some sharps boxes were unlabelled and some sharps items were incorrectly stored. We also found that there was a backlog of waste amalgam which had not been collected for seven months. Clinical waste, amalgam, lead foil, extracted teeth and gypsum were stored in the same store cupboard alongside the dirty clinical laundry.

Hazardous chemicals were stored in a cardboard box awaiting disposal. Records to accompany these waste items had not been completed and there was no guidance available for staff to follow in the waste disposal folder. The IPC Lead at the practice told us that a member of the administrative team was dealing with the disposal of these items.

The dentists 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 procedures. On very rare occasion, a parachute chain or gauze was used to protect the airway.

A business resilience 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 Resuscitation Co-ordinator was in post who understood their responsibility for maintaining oversight of the defibrillator and emergency drugs kit. All staff we spoke with were aware of medical emergency procedure and knew where to find oxygen, emergency drugs and equipment. Records identified that staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED (automated external defibrillator). Simulated emergency scenarios were used to provide practical learning. An AED was available in the dental centre in addition to two stored in the medical centre nearby. Daily checks of the medical emergency kits were recorded and demonstrated that all items were present and in-date.

The medical emergency kit was located in the corridor outside the surgeries during working hours and then secured in a surgery when the practice was closed, including during the lunch hour. Signage was in place to identify the location of the oxygen.

A first aid kit, bodily fluids and mercury spillage kits were available. 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 Crown indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

Monitoring health & safety and responding to risks

A number of organisation-wide, alongside local health and safety policy and protocols were in place to support with managing potential risk. However we noted some gaps. The fire risk assessment was slightly overdue, but was comprehensive and included risks and contingencies. Staff received annual fire training and evacuation drills were scheduled; the most recent drill took place in October 2017. Fire alarms were tested weekly. The COSHH (Control of Substances Hazardous to Health) risk assessment had not been updated since 2015 and there were no routine environmental checks undertaken to ensure that the building was safe for patients and staff.

The practice manager was the lead for health and safety for the practice and had received relevant training for the role in October 2013. A comprehensive range of risk assessments were in place. However regular building and environmental checks had not been undertaken. Records demonstrated that most staff were up-to-date with health and safety training. Training was provided at induction and through on-line courses. A risk register was in place for the practice and this was monitored by the practice manager and Senior Dental Officer.

The COSHH risk assessment was last updated in May 2015 and so was significantly out of date. Product data sheets were available for staff to fill out, but these did not contain specific information about the products held on site, how to safely handle them and storage and emergency measures in case of an accident. We were unable to access the cleaning cupboard as it was locked and practice staff did not have access to the key.

Infection control

An Infection prevention and control (IPC) policy was displayed on the CSSD notice board. However it did not detail who the IPC lead at the practice was and had not been signed by the Senior Dental Officer. It included 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. It was also available electronically. One of the dental nurses had been appointed as lead for IPC in May 2017. Terms of reference for the role were in place, but the IPC lead had not received relevant training for the role (a Dentisan course or equivalent). Other practice 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 each of the surgeries. Sterilisation was undertaken in accordance with HTM 01-05. Staff told us that routine checks were in place to
monitor that the ultrasonic baths and autoclaves were working correctly. However, records of temperature checks and solution changes had not been maintained.

The surgeries, including fixtures and fittings, were tidy, clean and clutter free. Clean and dirty areas were clearly labelled (with the exception of the partial CSSD area) and were used correctly by staff.

Instruments and materials had not always been checked: the sterilisation use-by-date was not always in place and we noted an item that had expired. IPC audits were undertaken twice a year by the IPC lead. The last audit was undertaken in September 2017. There were 12 points that had been noted in the audit, but these issues continued to be outstanding and had not been addressed. The comments recorded throughout the IPC audit report demonstrated a training need. Responses included comments such as ‘hopefully’, ‘not sure’ and ‘some do’. The IPC audit did not afford sufficient assurance that infection control procedures were effective.

The legionella risk assessment for the practice was not available on the day of the inspection. However the Senior Dental Officer provided a copy legionella risk assessment that had been carried out on the QEMHC and it was specific to the requirements within a health centre.

Environmental cleaning was carried out by a contracted company once daily for a period of 1.5 hours. Given the number of dental chairs and treatment rooms, this cleaning time is considered insufficient. Furthermore, the Infection Control Audit conducted in September 2017 identified issues with furniture and fixtures not being visibly clean and not free from dust, dirt and debris.

**Equipment and medicines**

Equipment logs were maintained to keep a track of when equipment was due to be serviced. Autoclaves had been serviced and replaced as necessary. All other routine equipment checks, including clinical equipment, were in-date and in accordance with the manufacturer’s recommendations. An equipment service audit was undertaken annually. A safety test of portable electrical appliances had been completed.

Prescription sheets were numbered and stored securely. Antibiotics were held at the practice and an antibiotic audit had recently been undertaken. Medicines that required cold storage were kept in a fridge, the temperature of which was checked twice daily. Nursing staff knew what to do if temperatures fell outside safe parameters.

Checks of medicines, including controlled drugs, were routinely undertaken by the practice staff with periodic checks by the SDO and the regional dental team.

**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 dentists justified, graded and reported on the X-rays they took. In accordance with current guidance and legislation each dentist carried out an annual radiology audit. 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

Patients’ treatment needs were assessed by the dentist in line with recognised guidance. For example, wisdom teeth management was conducted in line with NICE and SIGN guidelines. Treatment was planned in accordance with the BPE (basic periodontal examination - assessment of the gums) and caries (tooth decay) risk assessment. The dentists also followed appropriate guidance in relation to recall intervals between oral health reviews. Feedback from patients indicated that the assessment and treatment they received was comprehensive and effective.

We looked at patients’ dental records to corroborate our findings. 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 completed a detailed medical and dental history form at their initial consultation and this was verbally checked for any changes at each subsequent appointment.

Health promotion & prevention

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 the medical centre for advice about smoking, diet and alcohol use.

Oral health promotion boards were evident in the patient waiting area. Staff said the displays were refreshed on a regular basis and they often targeted to population need and/or seasonally 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 barracks.

The SDO attended unit health committee meetings with unit commanders to provide updates on the military dental targets and review the status of failed attendance at dental appointments (referred to as FTAs). Oral health promotion matters were also discussed, such as the uptake of smoking cessation.
Staffing

The practice referred us to a central policy which stated that staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. However our review of induction records and discussions with staff indicated that induction programmes had not always been completed, prior to clinical work being undertaken by new staff members. Two members of clinical staff had not received a detailed induction programme that covered all key areas, such as health and safety, 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 that there were some gaps in staff undertaking training they were required to complete. Gaps we identified were in safeguarding training and appropriate training for the IPC lead. Only one nurse had received additional training to apply fluoride varnish and to take dental impressions and staff told us that more nurses required training in order to meet patient needs effectively.

The system showed clinical staff were undertaking the continuing professional development (CPD) required for their registration with the General Dental Council.

Working with other services

The practice could refer patients to a range of services if the treatment required was not provided at the practice. For example referrals to Salisbury NHS Hospital for oral surgery. Previously patients could be referred for sedation to Devizes NHS Treatment Facility, although this service was no longer available. 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 and a nurse maintained a referral log and this was checked regularly to ensure urgent referrals were dealt with promptly, and other referrals were progressing in a timely way.

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 very satisfied that they received clear information about their treatment and treatment options were discussed with them.

Some staff we spoke with had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting, but some staff had less awareness of how the Act applied in their daily work. The SDO confirmed that it was unlikely that staff would need to apply the Mental Capacity Act in their dental work, although they acknowledged that it is best practice for staff to receive training as patients could present with heat exhaustion, mental health concerns or under the effects of alcohol. Practice staff confirmed that training had not been delivered at the practice.
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 57 feedback cards completed by patients prior to the inspection, suggested patients felt that they received a good standard of service. Emerging themes suggested that staff were approachable, that they provided good explanations about the care and treatment provided and that they received comprehensive, accessible dental care.

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. An alert could be placed on the patient’s electronic record to identify if they were anxious.

The waiting area was close enough to the reception for conversations to be overheard. Staff were mindful of this so had the options of playing a radio to aid with confidentiality. 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 the 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. One patient noted that their treatment had been delayed on two occasions due to faulty X-ray equipment and another noted that they had had difficulty accessing the practice by telephone.

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. Patients could make routine appointments between their recall periods if they had any changes to or concerns about their oral health.

Promoting equality

The premises were accessible to patients using a wheelchair and with reduced mobility. 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. 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. On-call arrangements were in place for access to a dentist outside of working hours and details of this were held at the guardroom should patients require this information when the practice was closed.

Concerns and complaints

The senior dental officer had overall responsibility for complaints. The practice manager had the delegated responsibility for managing the complaints process. A process was in place for managing complaints, including a complaints register. Staff told us that verbal complaints were not recorded, although they were responded to. Recording of verbal complaints and review of trends could support improved learning at the practice.
Our findings

We found that this practice was not well-led in accordance with CQC’s inspection framework

Governance arrangements

The senior dental officer (SDO) 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. We spoke with a number of staff who told us that they were not always clear about lines of accountability. Not all staff knew who they should approach is they had an issue that needed resolving.

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 2015 and a management action plan was in place to address a number of issues.

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. We noted that work was required to ensure that effective risk management processes were in place and followed by staff, particularly to govern environmental risks, needles and sharps and clinical waste management. Some checks and audits were in place to monitor the quality of service provision, but the Infection Control audit was not adequate to give appropriate assurance.

There was a need to establish clear lines of communication within the practice. Some staff told us that they did not know who they should go to if they had an issue to resolve. Some staff stated that they did not feel well supported or valued. A 20 minute informal team meeting was held each week to check the workload/activity for the week and staff were encouraged to write down any issues they needed addressing in a book. Staff fed back that this was a positive way for them to give anonymous feedback and to have some issues resolved. The main forum for sharing information was through formal practice meetings held each month. The meetings took into account managerial and clinical matters and were minuted.

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. All staff (excluding locums) participated in peer review at the quarterly regional dental meetings.

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 we spoke with reported that they were proud of the standard of care they provided. Some staff were confident that there was an open and transparent culture in place and that they knew how to address any concerns they might have. However other staff commented on a feeling of helplessness and referred to a blame culture which was fed by productivity led vision and values. The practice team were delivering good clinical care to patients, but high staff turnover and loss of staff resource to plug gaps at other practices in the region had a negative impact on staff who worked beyond their hours to deliver the care required.

Staff resource and skills mix are managed and determined by the Regional Headquarters. Staff shortages were not managed as effectively as they could be. We noted that on regular occasions, staff at Dental Centre Tidworth were allocated to clinics at other dental centres across the region, leaving gaps and reducing stability at Tidworth. The net result had been cancellation of patient appointments.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were not always effective. Radiology audits were undertaken by all clinicians and were in line with IRMER requirements. However, the concerns that we found across infection control and health and safety management demonstrated that audit work in these areas had not led to improvement. Nevertheless, dental military targets, failure to attend appointments, third molar referrals, recall intervals and the recording of consent were being routinely monitored.

The staff team attended a regional training day, 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 put in place to seek patient feedback but 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 this was monitored it on a regular basis.

A system was in place for staff to provide anonymous feedback and to suggest improved ways of working by means of a booklet in the staff room. Staff told us that they thought that this was an effective tool.