Overall summary

We carried out an announced comprehensive inspection of Innsworth Dental Centre on 12 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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<th>Are services safe?</th>
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<tr>
<td>Are services effective?</td>
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<td>Are services caring?</td>
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<td>Are services responsive?</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 Officer General’s office.

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

Background to this practice

Located in Imjin Barracks just outside Gloucester, Innsworth Dental Centre is a three chair practice providing a routine dental service to a military population of 2092, including international military personnel. In addition, the practice provides a service to 100 office-based Ministry of Defence personnel located in Bristol.

The mission statement for the practice is “To Deliver effective military dentistry that contributes to force generation and enhances operational capability.”

The team of military and civilian staff included three dentists (one part time), including the senior dental officer (SDO), two dentists and four dental nurses. A practice manager manages the day-to-day running of the practice. The dental centre is open Monday to Thursday from 08:00 to 16:30 and on Fridays from 08:00 to 14:00. 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 manager. During the inspection we spoke with the practice manager, the senior dental officer, two dentists, three dental nurses and the cleaning supervisor. 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 39 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, accidents and significant events.
- Systems were in place to support the management of risk, including clinical and non-clinical risk.
• Suitable safeguarding processes were established 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. Their required training was up-to-date and they were supported with continuing professional development.
• The clinical staff provided care and treatment in line with current guidelines.
• Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
• The appointment system met patient’s needs.
• The practice had effective leadership. Staff felt involved and supported, and worked well as a team.
• The practice asked patients for feedback about the services they provided and made improvements to the service based on the feedback.
• An effective system was in place for managing complaints.
• Medicines and life-saving equipment were available in the event of a medical emergency.
• Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
• Systems for assessing, monitoring and improving the quality of the service was in place.

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

• In relation to the facilities used for treating patients and for the decontamination of dental equipment, review the drain covers located in the floors of the surgeries 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 arrangements for the effective and safe management of water systems giving due regard to Approved Code of Practice and Guidance L8, Health and Safety Executive (ALCOP L8) and HTM 04-01: The control of Legionella, hygiene, ‘safe’ hot water, cold water and drinking systems.

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 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. They 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).

The practice manager maintained a log of significant events, including the action taken and lessons learnt. The log identified that eight significant events had been reported in the last 12 months. Significant events were a standard agenda item for discussion at the monthly practice team meetings. We noted from the minutes of the meeting held in December 2017 that two significant events had been discussed.

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). The MHRA and CAS alerts received were logged and saved. As a standard agenda item, they were discussed at the monthly practice meetings. If an alert needed to be shared urgently then it was discussed with staff at the Monday briefing meetings.

Reliable safety systems and processes (including safeguarding)

The senior dental officer (SDO) was the safeguarding lead for the practice and had completed level 2 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, and was accessible to provide staff with information about identifying, reporting and dealing with suspected abuse.

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. If a nurse was unavailable then the patient list was reorganised to ensure support for the dentist. The practice provided an example of how this situation was effectively managed recently when two staff were unable to work due to illness.

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. All staff completed training in August 2017 about how to raise concerns.

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 procedures.

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. This had been updated in September 2017 to take account of issues with the drains which led to water seeping into the building.

**Medical emergencies**

A member of staff was identified as the lead for medical emergencies. 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). This training was refreshed every six months; last refresher training was in October 2017. Simulated emergency scenarios took place every six months. The AED was stored in the co-located medical centre and a scenario had not been undertaken to include the length of time it took to get the AED from the medical centre. Shortly after the inspection the practice manager confirmed a scenario had been undertaken that included the use of an AED. 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. The controlled drugs (medicines with a potential for abuse or addiction) used in the event of a medical emergency were stored along with the emergency kit. Staff confirmed that patients were always escorted to and from the surgery. Shortly after the inspection we received a risk assessment from the practice manager formalising this arrangement to ensure the safety of controlled drugs. Signage was in place to identify the location of the oxygen.

A serious medical emergency had happened shortly before our inspection. It had been managed effectively and recorded as a significant event. However, it was identified that staff shouting for assistance could not be heard by staff at the other end of the building due to double fire doors that were required to be closed. As a result of this, a request had been placed for a panic alarm system to be installed. The practice manager said they would also explore whether automated openers for the fire doors would be an effective option.

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 indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

Even though staff identified that the practice would benefit from a receptionist, we found 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.

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 available for staff to access. A health and safety officer was identified for the barracks and they conducted an annual health and safety inspection of the premises in July 2017. It took account of matters such as, fire, risk assessments and COSHH (Control of Substances Hazardous to Health); no actions were identified from that inspection.

The practice manager was the lead for health and safety for the practice and had received relevant training for the role. They checked the building each month and kept records of these checks. A wide range of risk assessments were in place for the practice, including assessments for the environment, personal protective equipment and sharps injuries. Records demonstrated that 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.

The management of fire systems at the practice was undertaken by the health and safety department for the barracks. The five-yearly fire risk assessment had been undertaken in May 2016 and fire safety checks of equipment were undertaken annually. The practice manager was responsible for the weekly and monthly tests of the fire system and firefighting equipment. Staff received annual fire training and the building manager coordinated an annual evacuation drill; the most recent drill took place in November 2017.

The practice manager was the lead for the management of COSHH and carried out an annual review of the COSHH products used at the practice. The last review was undertaken in August 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 practice manager’s office. 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. It was also available electronically and a laminated version was available in all surgeries. 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 each of the surgeries. 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. In each of the surgery floors, we observed a number of secured drainage type covers approximately 25 centimetres in diameter. A request (statement of need) had been submitted by the SDO in October 2017 for the flooring to be replaced because the drain covers were assessed as a potential cross-infection risk and trip hazard. It was unclear what the drain covers were in place for so a contractor visited the practice and attempts to open the drain covers were unsuccessful. The practice was advised that funding was not available to remove the drain covers and replace the flooring.

Instruments and materials were checked regularly; we noted they were appropriately stored and all were within their sterilisation use-by-date. IPC audits were undertaken twice a year by the IPC lead. The last audit was undertaken in October 2017. 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.

In response to brown coloured water from all outlets when the practice had been closed for an extended period over Christmas 2016, the practice had introduced a process for running all water outlets each morning and records were maintained to ensure this happened.

The practice manager advised us that a legionella risk assessment had been carried out for the building by a contractor for the Ministry of Defence. Despite making a number of requests, the contractor would not share the risk assessment and written waterline management scheme with the practice manager. Therefore we were unable to confirm that water was safely managed in accordance with the Approved Code of Practice and Guidance L8, Health and Safety Executive (ALCOP L8) and HTM 04-01: The control of Legionella, hygiene, ‘safe’ hot water, cold water and drinking systems.

The contractor did provide a copy of the 2017 temperature checks of the sentinel taps (nearest and furthest water outlets from both the hot and cold water supply) ahead of the inspection. The records showed that for nine months of the year (February to October) the temperature of at least one sentinel water outlet was below the requirement of more than 55 degrees (temperatures recorded as low as 42.8 degrees). The dental team were unaware as they had not been informed about this and were unable to let us know what had been done about it. At our request, the contractor confirmed during the inspection that the matter had been addressed. The contractor also arranged for the water temperatures to be checked during the inspection and they were within the required 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**

Equipment logs were maintained by the practice manager that kept a track of when equipment was due to be serviced. The autoclave was installed in September 2016 and we noted the annual servicing was overdue. The practice manager was aware of this and had had been in touch with the service team. The practice manager confirmed the day after the inspection that the autoclave was being serviced that day. 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 was undertaken in August 2017.

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 daily. Temperatures were marginally outside of the required parameters for safe storage. There was no protocol outlining the action to take if temperatures were outside of these parameters. Shortly after the inspection and despite adjusting the fridge thermometer, the practice manager advised us it was still not working correctly. They confirmed a request had been submitted for a new thermometer and that processes had been updated to clarify the action to take if there were concerns identified with fridge temperatures.

Checks of medicines, including the controlled drugs, were undertaken by the practice manager with periodic checks by the SDO. To ensure external scrutiny going forward the practice manager confirmed shortly after the inspection that they had contacted the regional pharmacist and arrangements had been put in place for quarterly external checks to take place.

The temperature of the stock room containing medical products requiring storage under a specified temperature was not being monitored. Shortly after the inspection the practice manager confirmed that a thermometer had been ordered for the room.

**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

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 for the majority of patients the records 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.

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 dentists also followed appropriate guidance in relation to the management of wisdom teeth and recall intervals between oral health reviews. Feedback from patients indicated that the assessment and treatment they received was thorough.

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 displays 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 every six months.

The SDO attended quarterly 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**

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 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. Nurses had received additional training to apply fluoride varnish and to take dental impressions.

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.

**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 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 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 early in 2018.
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 39 feedback cards completed by patients prior to the inspection, suggested patients were pleased with the way staff treated them. Emerging themes suggested the service was flexible and that staff were professional and friendly, providing good explanations about the care and treatment provided.

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. 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 a radio and television to aid with confidentiality. The answerphone had been moved into a back office to ensure messages left by patients were not overheard by patients in the waiting 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’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.
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 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.

The practice clearly took account of population needs and preferences. The practice manager highlighted changes that had been made as a result of patient feedback about the service. For example, the practice provided a service to personnel working at a Ministry of Defence (MoD) base located 36 miles away in Bristol. Feedback from patients suggested the sick parade (emergency appointments) allocated time in the morning did not accommodate travelling at a reasonable time and the possibility that patients may need to book MoD transport. As a result of this feedback, sick parade ceased and the practice introduced staggered emergency appointments throughout the day. Patients could also book one of these appointments in advance on the same day or the following day. The practice also ensured recall appointments were booked at a time to accommodate the need of patients travelling to the practice.

Promoting equality

An access audit as defined in the Equality Act 2010 had been completed in October 2017 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. A ramp was in place to accommodate wheelchairs and an accessible toilet was available in the medical centre which could be accessed internally from the dental centre. 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 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 verbal 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. The practice made a change to the dentist’s diary as a result of this complaint.
Our findings

We found that this practice was 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. All staff were accountable to the SDO.

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 November 2015 and all improvement actions identified had been completed. The current CAF showed full compliance with the standards.

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.

Clear lines of communication were established within the practice. An informal team meeting was held each Monday to check the workload/activity for the week and ensure sufficient staffing and skill mix. The main forum for sharing information was through formal practice meetings held each month. The meetings took into account managerial and clinical matters and we noted the meeting minutes were detailed.

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. Clinical staff also 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 spoke favourably of the leadership at the practice, indicating 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. The SDO provided us with an example of how patients were informed of a cross-infection incident, received an apology and were reassured both verbally and by letter. This had also been recorded as a significant event.

**Learning and improvement**

Quality assurance processes to encourage learning and continuous improvement were evident at the practice. A programme of audit was in place including: an infection prevention and control (IPC) audit every six months; radiology audit; antibiotics audit. Audits were also undertaken in relation to complaints, equipment and health and safety. Evidence was in place to demonstrate that action and/or improvement had been made as a result of audit. For example, an IPC audit resulted in a request for drain covers in surgeries to be removed and a ceiling light attachment replaced. In addition, dental military targets, failure to attend appointments, third molar referrals, recall intervals and the recording of consent were also being routinely monitored.

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 Officer General each year. The appraisal process also encouraged staff to give feedback on the service.