We carried out an announced comprehensive inspection of DMS Centre for Restorative Dentistry on 6 March 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></th>
<th>No action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>✓</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>✓</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>✓</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>✓</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>✓</td>
</tr>
</tbody>
</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 Surgeon General's office.

This inspection was led by a CQC inspector and supported by two dental specialist advisors.

Background to this practice

The Centre for Restorative Dentistry (CRD) is a specialist, secondary care department which receives referrals from Defence Primary Health Care (Dental). The CRD provides advice, diagnosis and treatment for military patients in the UK and military dependants and entitled civilian personnel overseas. Referrals may be for orthodontic treatment, root canal treatment, implants, crowns, bridges, periodontal treatment or a mixture of interdisciplinary specialisms. The CRD also provides outreach clinics in Cyprus, Scotland and Germany. There are four dental officers working in CRD who provide specialist treatment including two restorative consultants and one orthodontist. These clinicians, following consultation with patients and colleagues, can also refer onwards to additional specialists such as oral and maxillofacial surgeons.

The practice has its own laboratory on-site where specialist staff work to produce bespoke prosthetics and appliances for patients. On completion of the course of treatment from CRD, patients are referred back to their general dental practitioner who can provide routine maintenance and supportive care.

How we carried out this inspection

On the day of inspection we collected 47 CQC comment cards filled in by patients. Patients gave consistent and highly positive feedback on the practice. We spoke with two patients on the day of inspection. Both patients described the care they had received as being of the highest quality, and said that the results of their dental restoration has been beyond what they expected.

During the inspection we spoke with three dental specialists, three dental nurses, one member of reception staff and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The practice was clean and well maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems to help them manage risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for
safeguarding adults and children.

- Where specialist staff were required, these could be attracted based on the innovation and reputation of senior clinicians and the centre’s ability to deal with complex cases.
- The clinical staff provided patients’ 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. The centre opening hours were aligned to patient need, especially those travelling considerable distances for treatment.
- The practice had leadership which was inspirational, innovative, effective and supportive. Staff felt involved and supported and worked well as a team. We particularly noted the close daily working relationship between senior dental specialists and the on-site laboratory staff.
- The practice consistently sought feedback from patients and visiting professionals, on how practice could be improved.

We identified the following notable practice, which had a positive impact on patient experience:

- The lead clinician, along with the other dental specialists had identified a specific set of skills required for laboratory staff working at the centre. When seeking to fill a recent vacancy, the clinical team had been through three recruitment cycles to secure a candidate with this specific skill set. This appointment was a significant factor in retaining the on-site laboratory facility for the centre, which benefitted patients.
- The dental specialists, supported by the clinical lead, undertook extensive audit and research work, which was published and shared with stakeholders, including the NHS Chief Dental Officer, England. This contributed to the advancement of dental restorative techniques in Defence Dental Services as well as in some NHS work.
- The centre clinicians worked closely with the lead maxillofacial surgeon at the local NHS hospital, who visited the centre up to twice each month to assess and review patients. The ability to offer patients this joined up care and treatment, was a particular feature of positive feedback from clinicians and patients.
- The practice clinicians put considerable additional time and effort into writing business cases and bids to secure additional equipment and advanced technologies. These were used to provide patients with a single point of access to advanced dental care and the manufacture of dental appliances, for example, by using three dimensional imaging techniques.
- The daily involvement of laboratory staff with the clinicians in the centre meant closer working relationships and the ability to adjust appliances for patients at their appointment. This meant fewer visits to the centre for patients. This was reflected in the highly positive feedback provided by patients.

This meets with the criteria of notable practice within the military setting.

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

- Ensure that premises and equipment used by the service provider are properly maintained and suitable for the purpose for which they are being used. For example, in relation to the current practice of cleaning and decontamination of instruments in the surgery rooms, rather than in a dedicated unit and; the need to upgrade fixtures and fittings within the centre to fully comply with
infection control requirements.

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

Underpinned by policy and procedure, the practice used the DMS wide electronic reporting system to record, report, investigate and learn from significant events and near misses. Staff were aware of their role in the reporting and management of incidents, including any incidents that required reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager advised there had been one significant event in the past 12 months. This involved a needle stick injury to one of the clinicians. As a result of investigation of the event, the practice had introduced the use of Insafe boxes. Following audit on the use of Insafe boxes, these were approved for use across DMS dental practices.

The practice staff could explain how they kept up to date on the outcome of significant events reports at other practices, and how this knowledge was shared through bulletins and Clinical Operative Directives (COD), which were discussed at practice meetings. The practice manager told us how they received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Department of Health Central Alerting System (CAS). They checked the CAS system regularly for updates and shared any relevant alerts with staff at practice meetings.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead for the practice. All cases seen at the centre in the UK, and in outreach clinics in UK were adults. Children and family members were seen in overseas clinics. All staff were aware of their responsibilities in relation to any adult patients who may be vulnerable. A safeguarding policy and procedure was in place to provide information about identifying, reporting and referring any cases of suspected abuse or other safeguarding concerns. The practice manager explained that all dental specialists were supported by a dental nurse.

Evidence we reviewed on the inspection day showed all staff had received safeguarding training relevant to their role, and this was was refreshed at least every three years. There had been no safeguarding incidents raised by the CRD. When operating peripatetic clinics overseas, staff would follow DPHC policy and procedure and refer to local safeguarding protocols.
A chaperone policy was in place and notices explaining the policy were located in patient waiting areas. All dental clinicians had designated nurse support and never worked alone. A lone working risk assessment was in place in respect of any administrative staff that worked alone. A whistleblowing policy was in place. All staff could refer to this, explain what a whistle-blower was, and how they would raise concerns with Defence Primary Health Care (DPHC) if they were unable to speak with someone within the practice. Staff also referred to Principle 8 of the General Dental Council (GDC) standards. All clinicians and dental nurses were registered with the GDC.

When we reviewed patient records we saw that treatment plans referred to relevant guidance and risk assessments in place to support safe treatment and uphold patient safety.

Medical emergencies

Staff knew what to do in a medical emergency. All staff had received training in basic life support and emergency resuscitation. A record of this training was held by the practice manager, who ensured that any staff due for refresher training, received this without delay. All staff had received training in the use of a defibrillator. Regular simulated emergency scenarios, as required by the GDC for training purposes, were carried out in February 2018.

Emergency medicines and equipment were available in a safe but secure location within the centre, and these could be accessed quickly. Daily checks were carried out to ensure that all medicines were in date and ready for use and that all equipment was serviced and suitable for use. All staff had received first aid training and a first aid kit was available for use. Kits to deal with spillages of bodily fluids, mercury and bio-hazards were available and accessible to staff who had been trained in the safe use of these.

Staff recruitment

The full range of recruitment records for staff at the practice, were held centrally by the relevant Defence Primary Health Care Regional HQ. However, the practice manager held some key checks at practice level to ensure safety and security of patients and staff. These included periodic checks on registration and indemnity cover of clinicians, validity of Disclosure and Barring Service Checks (DBS), and records of staff immunology and vaccination history.

All clinical staff were registered with the General Dental Council (GDC) and had professional indemnity cover in place. The practice manager was able to show us a log of all professional registrations and when these were due for review.

As the skill set of staff at the centre was specialist, the clinicians, including the Senior Dental Officer (SDO), played a key role in recruitment for the centre. All clinicians at the centre agreed that this contributed to them being able to provide patients with a comprehensive, bespoke service.

Monitoring health & safety and responding to risks

Organisation wide health and safety policies and protocols were in place and observed by all staff, helping to manage potential risks. All staff took part in health and safety training every two years. There was a Safety, Health, Environment and Fire department which carried out routine health and safety risk assessments of the premises. The practice manager said that any reported health and safety concerns were dealt with promptly and any maintenance requirements were actioned without undue delay. The last fire risk assessment was completed in July 2015 and is due for...
review on 10 July 2020. We reviewed records which confirmed that a fire alarm test was carried out weekly; fire evacuation drills were carried out annually. Monthly checks on fire extinguisher equipment were conducted by the practice manager and records kept to confirm this.

We were able to review records that showed a full Control of Substances Hazardous to Health (COSHH) assessment was carried out in March 2017 and was due for review in March 2019, unless any safety notification indicated otherwise.

Infection control

An infection prevention and control policy was in place at the centre. This reflected guidance in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05), published by the Department of Health. There was a designated lead within the centre for infection control, and an appointed deputy. We saw that all staff had received training in infection control and aseptic techniques and that this was monitored to ensure it was refreshed regularly.

A dental nurse demonstrated the process for cleaning and sterilising of equipment. The centre does not have a purpose built, central sterilisation and decontamination unit at the practice. Instrument cleaning and decontamination procedures were conducted in each surgery. To facilitate this there was a clear, one way flow of instruments from clean to dirty. Instruments were washed in bowls within the surgery and rinsed in a sink. An ultrasonic bath was used and we saw that the Neutrasan fluid used was changed at least twice daily. An area was set aside for inspection of instruments using a magnification tool and light. Instruments were sterilised in an autoclave, for which records of temperature checks were held for each cycle. We examined packed instruments which were all date stamped. We saw that all staff had access to and used the appropriate personal protective equipment (PPE). The arrangement in place for cleaning and sterilising of equipment was adequate but given the throughput of patients at the centre and the list of patients awaiting treatment, this could be improved to make best use of time of the surgeries, clinicians and dental nurses.

A management plan was in place to reduce the possibility of Legionella or other bacteria developing in the water systems. The last full risk assessment was completed by an external contractor in April 2017. When we reviewed the plan and checks in place, we saw that water lines were flushed daily before the start of surgery for at least two minutes. Lines were also flushed for 30 seconds between patients. Water bottles were managed appropriately, and were emptied and flushed on a weekly basis using Bioclear in accordance with manufacturer’s instructions. A dip-slide was used weekly to check for any biofilm residue.

The practice was clean, tidy and clutter free. External cleaners performed cleaning duties twice daily. Cleaning equipment was stored in line with guidance but was accessible to staff if required. However when making checks on cleaning and infection control standards, we did note there were rips and tears in some of the dental chairs. There was damage to the flooring and work surfaces of at least two of the treatment rooms. We were told these had been reported to the unit on several occasions. Records held showed this to be in October and November of 2017 and February 2018. This was also highlighted in the most recent infection control audit.

Equipment and medicines

Equipment logs were in place to record and track when equipment was due for service or replacement. Service records we reviewed showed that all technical equipment used by clinicians was serviced by Defence Electronics and Components Agency; Cone Beam Computed
Tomography (CBCT) equipment was serviced by the manufacturer in accordance with guidance. Autoclaves, compressors and ultrasonic baths had servicing stickers on them and certificates of service were held by the practice manager. Routine equipment checks were in place and records of these were available for review. We saw that all checks were up to date. Portable appliance testing had been carried out and stickers on appliances showed that this was completed in March 2018.

The practice manager held records that demonstrated prescription pads were managed safely and securely. All serial numbers of batches of prescriptions issued to clinicians were recorded in spreadsheets. Any transfer of batches of prescriptions from one clinician to another were clearly recorded. Monthly and weekly stock level and expiry date checks were carried out for medicines held within the practice. A register was kept in respect of accountable drugs and a weekly and monthly return was completed to record use of these medicines. Those medicines that required refrigeration were stored correctly and fridge temperature checks were recorded daily. The practice clinicians did not carry out sedation at the centre.

Radiography (X-rays)

As this was a referral practice, additional radiographic imaging capability was available, including CBCT, lateral cephalogram and orthopantogram imaging.

The practice had arrangements in place to ensure the safety of X-ray equipment. The practice was meeting current radiation regulations and held the required guidance documents and information in a radiation protection file. Local rules were held in the radiation file and were also held in each room alongside the x-ray equipment they related to. Specific rules for CBCT were held in the x-ray suite.

A review of an anonymised sample of dental records showed that each clinician justified, graded and reported on each set of radiographs they took. In accordance with guidance, the practice carried out audits on x-rays taken. We saw evidence of well thought out audits designed to improve the quality of radiographic reporting, appropriateness of referrals and evaluation of the service.

All clinical staff were up to date with dental radiography training and had completed updates on this as required and were able to evidence this as part of their ongoing continuous professional development.
Are services effective?
(for example, treatment is effective)

Our findings

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

Monitoring and improving outcomes for patients

We reviewed a sample of anonymised patient records. We saw comprehensive and detailed notes held in respect of each patient. These covered treatment options, the risks and benefits of each option and the timeline for treatment, detailing the level of supportive care required not only from the centre but also from the primary care dental team at the patient’s own practice. We also saw evidence of discussion with patients regarding the requirement for long term maintenance, including for when the patient left the service and how the cost of this may influence the decisions made by each patient. We saw from patient notes that consent to care and treatment was recorded at each intervention, with evidence of further discussion of next steps on the treatment pathway.

All clinicians we spoke with were able to provide clear explanations and information to patients on how restorative/orthodontic/surgical treatment would improve their oral health. Added to this, clinicians could demonstrate, for example, their expertise in how patient’s speech could be improved and how the aesthetic appearance of restorative work could impact on patient well-being and quality of life. In doing so clinicians confirmed their high level understanding of patient’s needs, and how working with other medical professionals facilitated quality outcomes for patients. For example, by working closely with the maxillofacial surgeon who visited the centre and other medical professionals involved in post-operative care.

Health promotion & prevention

From the sample of notes we reviewed we saw that clinicians at the centre liaised closely with the dental practitioners within the primary care setting, especially regarding the levels of oral and periodontal care required to support the more complex treatment provided by the centre. Patients were also given support and information on how high standards of oral care would support the best outcome for their treatment. We spoke with two patients. Both told us that clinicians were particularly good at explaining how they should maintain their implants, appliance or prosthesis, to ensure treatment was successful. Patients also told us that liaison between their primary care dentist and the centre was good and that at oral health checks in primary care, clinicians understood their treatment pathway and the support required for that patient.

We saw that health promotion information was available to patients in the reception and waiting areas shared with Aldershot Dental Centre. This was relevant to the patients being treated at the centre. There was information on the impact of diet and sugary drinks on dental health. Information was provided on the effects of smoking on oral health, and education on this is provided at primary care level.
Staffing

All staff new to the practice complete the DPHC dental induction package. Once completed the formal record of this was sent to regional headquarters. The practice manager carried out a structured, guided tour of the facility with all new and visiting staff, identifying fire escapes, first aid points and health and safety information relevant to the facility.

An organisation-wide electronic system was in place for the recording and monitoring of staff training, assessments and appraisal. We saw records that confirmed that all staff had received mid-term appraisals and that all training needs were recorded. Staff were able to show us how they maintained their continuous professional development and confirmed that the organisation was supportive in helping them to do this. All staff had been able to maintain their registration with the General Dental Council.

At the time of our inspection, the post of practice manager had been vacant or gapped for some time. One of the dental nurses had taken on this role. This left four dental nurses to support four dental clinicians. This meant that any leave had to be planned and co-ordinated across the team to ensure that dental clinicians could work with chairside support.

The clinical team was supported by one receptionist and one administrator. One of these staff was due to start a period of extended leave. To accommodate this, a dental nurse had committed to undertaking administrative work, which decreased the hours they would be available to assist dental clinicians. Practice leaders told us this made the running of the day to day business of the centre particularly tight, and that any unforeseen staff absences would have a direct impact on patients. The practice had been given approval to recruit a further dental nurse.

We asked about the throughput of patients for the centre. We were told approximately 519 patients were currently receiving treatment. Treatment could last between five to six months (average duration) and in some cases, four to five years. At the time of inspection, the centre held a waiting list which numbered approximately 230 patients.

Working with other services

The CRD worked closely with the oral and maxillo-facial surgeon from the local NHS hospital, who visited the centre twice monthly to meet and review patients for treatment. This multi-disciplinary team approach meant that the centre offered patients a seamless service from the point of referral from their primary care dental practice.

The Senior Dental Officer (SDO) had excellent links with other outside departments, for example, the Chief Dental Officer for England. This extended to the SDO sharing audits, the research work of the centre and paper produced by the SDO that had been published (seven papers published in 2017). The innovations shared with the NHS, contributed to development of new techniques in restorative dentistry.

The centre leaders had developed methods to enable NHS departments to access imaging records and x-rays of patients treated at the centre. This may be necessary when patients are admitted to hospital or accident and emergency units in an unplanned way. This helped reduce the possibility that the work done by clinicians at the centre may be compromised by non-life saving interventions during urgent admissions.

Throughout our reviews of anonymised patient records, we were able to confirm that strong
working relationships were in place between the centre and primary care dental practices. Feedback from patients support this. We saw evidence throughout our inspection that this contributed to positive outcomes for patients, particularly those who had undergone lengthy periods of treatment involving complex restorative work.

Consent to care and treatment

Staff we spoke with fully understood the principles of consent and the importance of recording this in patient consultations. We were also given examples where clinicians had recorded that patients had declined further treatment. In these cases clinicians had recorded what they had told the patient, what the impact could be of failing to finish a course of treatment, and what alternatives could be offered. Although this would have been disappointing to clinicians, we saw that patients’ choices were respected at all times. For all CRD procedures full written consent was obtained. All staff demonstrated a strong understanding of The Mental Capacity Act 2005 and gave examples of when they would apply principles of Gillick competence.
Our findings

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

Respect, dignity, compassion and empathy

Throughout our visit to CRD, we saw that all staff acted with respect, dignity and compassion towards patients. All comment cards completed by patients were highly positive about the way staff at the centre behaved towards patients. Patients commented that their opinions were valued and that all staff listened to them when discussing their care and treatment.

The layout of the reception area, which was shared with Aldershot Dental Centre, did not fully support the privacy and confidentiality of patients, especially when they reported to the shared reception desk. Staff told us that if any patient required greater privacy, they could take them to a private room. This would have been particularly important for patients in the early stages of treatment when speech may have been affected by any injury or post-operative recovery. We noted that computer screens were turned away from patient view and could not be seen by staff other than the receptionist. All patient records were stored electronically and these were password protected. Any paper records were stored securely.

Involvement in decisions about care and treatment

Evidence reviewed and collected on the day of inspection, alongside patient feedback confirmed that patients were fully involved in decisions about their care and treatment. Printed information that patients were provided with before any treatment, could be provided in other languages and formats. Patients told us they felt sufficiently informed of any risks associated with planned treatment and that they also understood the commitment required from them to ensure that their treatment was successful.
Our findings

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

Responding to and meeting patients’ needs

All patients visiting CRD had been referred by their primary dental practice or possibly following time in hospital. Most patients would be travelling significant distances to attend the centre. The staff at the centre were mindful of this and provided extended opening hours to allow travelling time for patients.

The centre had on-site laboratory facilities which significantly decreased the waiting time for some patients to have prostheses and appliances constructed and fitted and allowed any work to modify appliances to be done immediately if necessary, during the patient appointment. This is particularly important as many patients travel considerable distances to attend the centre. It also allows patients to speak directly with the makers of the prostheses and appliances, providing feedback that can inform the development, manufacture and fit of appliances and prostheses which benefits the patient.

Promoting equality

An access audit as defined by the Equality Act 2010 had been conducted in February 2018. An access audit forms the basis of a plan to improve accessibility of premises, facilities and services for patients, staff and others with a disability. This audit showed that all reasonable adjustments were in place. However there was no fully accessible toilet facility in the centre, but there was one available in the entrance hallway to the building, before the stairs leading to the centre. The stairs were serviced by a stair lift.

Access to the service

The planning of appointments for patients was key to ensuring each surgery ran smoothly. Because each intervention with patients was part of a course of bespoke treatment, the whole clinical team had committed to working more flexibly than primary care dental practices, to allow patients sufficient time to travel to the centre.

The regular opening times of the centre was advertised in the waiting room, on the front door of the centre and in the patient information leaflet. Core opening times were Monday to Thursday 0800 hours to 1730 hours and on Friday from 0800 hours to 1200 hours. Urgent treatment would be provided by primary dental practices. Feedback from patients showed these times were sufficient to meet patients’ needs.

Concerns and complaints

The Senior Dental Officer was responsible for managing complaints. A complaints policy and
protocol was in place. This provided guidance on how complaints should be handled. Staff had received training in the handling of complaints and demonstrated a good understanding of the complaints policy and procedures to follow. We reviewed a complaint that had been received in the past 12 months. We could see that this had been handled in accordance with the policy and that staff demonstrated compassion and understanding when responding to the concerns of the patient. Staff had also created a log to deal with any grumbles or feedback that was not completely positive. We saw that any entries were shared and discussed at staff meetings and that all feedback was used to improve the patient experience of treatment at the centre.
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 centre. The practice manager was responsible for the day to day running of the centre.

Throughout the day we saw strong governance processes underpinning all aspects of service delivery by the centre. The practice manager provided us with an overview of governance arrangements for the centre, including lines of reporting and accountability. A key governance document for the centre was the Healthcare Governance Assurance Audit, which, at the time of this inspection, is completed every two years. All clinicians and nurses voluntarily undergo 360-degree feedback as part of the appraisal process. All staff had evidence of appraisal.

The practice used audit to measure the quality of treatment and interventions for patients. For example, the various imaging techniques used were audited. Results helped promote the use of equipment that delivered the lowest possible doses of radiation, whilst providing the quality of image required, first time. This protected patients and helped identify which equipment could be used most effectively, dependent on the level of treatment required.

We saw that patient feedback was used at every opportunity to improve the patient experience of treatment at the centre. The Common Assurance Framework document provided the basis for monitoring the quality of the service. This was used as a living document which the practice manager kept under review. Through any of the governance processes, the only area that required improvement related to the central sterilisation and decontamination room.

Leadership, openness and transparency

Throughout our inspection, we saw leadership that was inclusive, motivational, supportive and inspiring. For example, we saw how leaders worked hard to bid for and secure equipment for the centre that would enable them to deliver complex dentistry. This was particularly difficult to achieve, given the competing priorities for military resources. At the heart of these bids was the desire of clinicians to help patients achieve a better quality of life. Although the aesthetic work done by clinicians had a big impact on patients, it also helped patients recover from speech problems caused by injury to the mouth and face, and allowed them to enjoy a regular diet without experiencing discomfort when eating. The passion of clinicians for their work was tangible. We saw how leaders were able to attract laboratory staff to work at the centre, based on the role the recruited staff member would play whilst working in a highly specialised team of clinicians. All clinicians at the centre agreed that this unique blend of staff skills enabled them to provide patients with an outstanding service.

When we spoke with patients visiting the centre, they described how they had received care and
treatment of the highest standards. We were told how clinicians and staff had worked with patients to enable them to make lengthy journeys to the centre. Patients described how their clinician had managed expectations and was open and honest about risks involved, but even then, results had been far better than anticipated by the patient and their family. This level of openness and transparency was also reflected in the feedback left by patients in comment cards, completed before our visit.

**Learning and improvement**

The use of audit at all levels was used to drive improvement. As well as the expected radiology audits, infection control audits and medicines audits, we saw audits on the manufacture of appliances and prosthetics. Evidence from audit of dental morbidity on military operations is currently being used to seek changes to NICE guidance on third molar removal, to reflect occupational need. The centre fostered strong links with external stakeholders including the Chief Dental Officer for England, teaching hospitals, dental schools, oral surgery departments and other NHS colleagues. Joint clinics at the centre were delivered with oral and maxillo-facial surgeons. All dental nursing staff were encouraged to progress and increase their breadth of experience and knowledge. All staff we spoke with described the centre as a positive learning environment. Several of the audits and research projects worked on by the lead dental clinician had been published. Ultimately, this benefitted not only patients of the centre, but those patients receiving treatment in wider NHS dental services.

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

The practice gathered feedback from patients and staff. There was a suggestion box in the patient reception area and this was placed separately to gather responses specifically from patients of the CRD. All suggestions, comments or complaints were logged, recorded and information carried over to the Common Assurance Framework return document.

We saw that feedback from patients, via surveys, compliments slips and CQC comment cards was overwhelmingly positive. Based on feedback from patients, the centre had provided more flexibility in working times, to accommodate patients making longer journeys to receive treatment.

Staff were encouraged to share ideas and feedback through meetings, regular one to one sessions with line managers and through the appraisal system. All staff we spoke with said the service constantly developed over time, based on the findings of audit, research and feedback. The close working relationship with staff in the on-site laboratory facility meant ideas could be shared easily and talked through, before trialling to see if they would enhance patient services or staff working practices. For example, the way appointments for patients were booked, would take into account any time needed by laboratory staff to make adjustments to appliances or prosthetics, if this was possible. This meant costs for the patient may be reduced as the patient did not have to make a return journey to the centre.