We carried out an announced comprehensive inspection of Dental Centre Harrogate on 15 January 2019.

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>Service Type</th>
<th>Action Required</th>
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<tr>
<td>Are services safe?</td>
<td>No action required</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Improvements required</td>
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<tr>
<td>Are services caring?</td>
<td>No action required</td>
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<tr>
<td>Are services responsive?</td>
<td>No action required</td>
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<tr>
<td>Are services well-led?</td>
<td>Improvements required</td>
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Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Defence Medical Services Regulator’s office.

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

Background to this practice

Located in Uniacke Barracks, Dental Centre Harrogate serves the Army Foundation College (the only Phase 1 Junior Entry training establishment in the British Army). The three-chair practice provides a routine dental service to new army recruits aged 16 to 18 years, as well as to permanent staff members of the armed forces based at the College. The practice confirmed to us that many young recruits and soldiers had greater than average dental care needs. This relates to oral health demographics with an above average percentage of the dental centre patient base recruited from areas of deprivation and poor oral health. At the time of inspection, the practice patient register numbered approximately 1,300 patients, with approximately 960 of these being 16 to 18 year old recruits to the Army.

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 eight posts and the current establishment and staffing gaps are outlined in the table below:

<table>
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<th>Position</th>
<th>Incumbent</th>
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<tr>
<td>Military Senior Dental Officer</td>
<td>Military staff in post</td>
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<tr>
<td>Military Practice Manager</td>
<td>- GAPPED -</td>
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<tr>
<td>Military Dental Nurse</td>
<td>- GAPPED -</td>
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<tr>
<td>Civilian Dental Practitioner</td>
<td>Civilian dentist in post</td>
</tr>
<tr>
<td>Civilian Dental Nurse</td>
<td>- GAPPED -</td>
</tr>
</tbody>
</table>
On the inspection day, four of these posts were gapped (vacant). The practice manager post is currently vacant, awaiting the arrival of a new manager in March 2019. A military staff member had been brought in from another practice to assist with management tasks in the interim, but they had not received practice manager training. There are no additional administrative or reception staff at this practice. A Principal Dental Officer and a Regional Dental Manager assume accountability for the quality of dental care provided at this centre and we interviewed them as part of our inspection. The dental centre is open Monday to Thursday 08.00 to 12:30 and 13:30 to 16:30 and on Fridays from 08:00 to 13.00. 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. During the inspection we spoke with the interim practice manager, the senior dental officer, one dentist and one dental nurse. 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 14 CQC comment cards completed by patients prior to and during the inspection. We also spoke with 15 patients who were attending the dental or medical centre for an appointment. All the feedback from patients was positive.

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 risks.
- 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. Most required training was up-to-date although the infection control lead had not received training specific to the role.
• The clinical staff provided care and treatment in line with current guidelines. Clinical notes were exemplary.

• Staff treated patients with dignity and respect and took care to protect their privacy and personal information.

• The appointment system met patients’ needs.

• 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.

• Medicines and life-saving equipment were available in the event of a medical emergency.

• Infection control guidelines were being followed and standards met.

• Systems for assessing, monitoring and improving the quality of the service were in place.

• Staff appreciated and responded to the leadership of the Senior Dental Officer who they saw as a hardworking and approachable leader.

• However significant gaps in staffing meant that workload was too high and unsustainable. We saw evidence that gaps in staffing had resulted in three clinics being cancelled within the last quarter, staff had not been released to attend infection control and fluoride varnish training and reception had, at times, been unmanned. We also noted that oral health promotion opportunities were being lost.

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

• Provide infection control training for the lead nurse.

• The regional management team should prioritise the provision of staff to this practice in support of DPHC’s commitment to deliver Project MOLAR: a treatment strategy to improve the dental health of personnel entering the military.

• DPHC should review its ability to fill key staffing gaps where clinical care might be compromised.

• Provide chairside/chaperone support for the hygienist.

**We found areas where practice was notable:**

• The business resilience policy and disaster recovery plan were comprehensive and presented in a way that was particularly easy and simple for staff to follow and implement in an emergency.

• The SDO (Senior Dental Officer) had worked collaboratively with staff from the AFC (Army Foundation College) to undertake a Group Action Project (GAP). The GAP was a compulsory element of a part-time MSc in Programme and Project Management that two training staff (non-dental) from AFC were undertaking. The project selected looked at dental failure to attend (FTA) rates and how to potentially reduce them. The entire dental team supported the project, which looked at all aspects involved and included stakeholders, patients, administration processes and systems. In June and July 2018, 65 patients had failed to attend their appointment and, following targeted work, this number had been reduced to three patients in October 2018. The reduction had been achieved through improvements to dental centre processes but also the AFC asking a single soldier to make individuals in their platoon aware of their dental appointments. This improvement trend has been sustained. The outcome was a
collaborative QI project that has been of benefit to both DC Harrogate and aided in the development of very young recruits.

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 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). The practice maintained a log of significant events, including the action taken and lessons learnt. The log identified that four significant events had been reported in the last 12 months. Significant events had been discussed at practice team meetings and staff we spoke with confirmed what they had learned.

The Senior Dental Officer (SDO) and Practice Manager were 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 and any required action undertaken. 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 three safeguarding training. All other members of the staff team had completed level two safeguarding training which was appropriate to their roles. 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 bespoke Army Foundation College (AFC) safeguarding policy and procedure was in place and contained the local contact details needed to appropriately signpost staff who needed to raise a concern. Staff told us that they could approach the SDO or the AFC safeguarding lead if they identified and needed to report suspected abuse. Practice staff understood the importance of working closely with welfare teams and chain of command and recognised the unique vulnerabilities of young service personnel in their care.

The dentists were always supported by a dental nurse when assessing and treating patients. Due to staffing constraints, nurses were unable to work as chaperones for the dental hygienist
who was only on site twice a month. Where staff worked alone at the practice, there was a lone working policy in place to guide staff.

A whistleblowing policy was in place and available to staff in the staff room and online. Staff described what they would do if they wished to report in accordance with the policy and we noted that a low-level issue had been dealt with appropriately recently.

We looked at the practice’s arrangements for safe dental care and treatment. These included risk assessments. The practice was following relevant safety legislation when using needles and other sharp dental items. A needle stick injury policy was available in all surgeries.

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.

A comprehensive 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 civilian dentist maintained oversight of the defibrillator and emergency drugs kit. All staff were aware of medical emergency procedure and knew where to find medical 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 medical centre which is in the same building. 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 medical 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 an enhanced Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in line with requirements.

The regional clinical operations team monitored each member of staff’s registration status with the General Dental Council (GDC). The SDO 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 local health and safety policy and protocols were in place to support with managing potential risk. The fire risk assessment was comprehensive and included risks and contingencies. Staff received annual fire training and evacuation drills were scheduled. Fire alarms were tested weekly. Portable appliance testing had been carried out in line with policy. A COSHH (Control of Substances Hazardous to Health) risk assessment had been undertaken,
along with routine environmental checks to ensure that the building was safe for patients and staff.

**Infection control**

An Infection prevention and control (IPC) policy was displayed on the staff room and CSSD (Central Sterile Services Department) notice board. 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. A dental nurse took the IPC lead at the practice, supported and overseen by the Senior Dental Officer. The IPC lead had not received relevant training for the role. Other practice staff were up-to-date with IPC training and records confirmed they completed refresher IPC training every six months. IPC audits were undertaken twice a year by the IPC lead and we saw that any issues had been swiftly resolved.

The surgeries, including fixtures and fittings, were tidy, clean and clutter free. Environmental cleaning was carried out by a contracted company once daily. Clean and dirty areas were clearly labelled and were used correctly by staff.

Decontamination of dental instruments took place in the purpose built CSSD. Sterilisation was undertaken in accordance with HTM 01-05. Routine checks were in place to monitor that the ultrasonic baths and autoclaves were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were routinely checked by staff: we saw that the sterilisation use-by-date was in place and we did not note any out of date items. There was scope to further reduce the risks of cross contamination by purchasing an additional magnifying glass and an additional clinical waste bin.

The legionella risk assessment for the practice had been undertaken by the station and it was specific to the requirements within a health centre.

**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 monthly checks undertaken by the SDO. Protocols were in place for the safe management of antibiotics and correct labelling techniques were in place. 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. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training, had received relevant updates.
To corroborate our findings, we looked at range of patient’s dental care 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.
Our findings

We found that this practice was not 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, although gaps in staffing meant that potential opportunities could not always be maximised. 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 to some patients, although there was scope to improve prescribing of this toothpaste by introducing an agreed protocol. Referrals could be made to other health professionals, such as referrals to the medical centre for advice about smoking, diet and alcohol use. The post of hygienist had been removed from the practice staffing establishment. A hygienist provided a service to patients two days each month; this was insufficient to proactively meet the needs of the population at risk.

The dental team participated in the health and wellbeing promotion fairs held at the barracks. We reviewed the materials used to provide young soldiers with supportive oral care information and found that they were appropriate and effective.

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**

Staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. Our review of induction records and discussion with staff indicated that induction programmes had been completed, prior to clinical work being undertaken by new staff members.

We looked at the organisational-wide electronic system that recorded and monitored staff training and appraisal. Through this, we confirmed that there was one gap in staff undertaking training they were required to complete; appropriate training for the IPC lead. A nurse was waiting to receive training to apply fluoride varnish, but due to resource constraints, this had been put on hold. Staff confirmed that more nurses required training 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.

At the time of our inspection, significant gaps in staffing meant that workload was high and unsustainable. We saw evidence that gaps in staffing had resulted in three clinics being cancelled within the last quarter, staff had not been released to attend infection control and fluoride training and reception had, at times, been unmanned. We also noted that oral health promotion opportunities were being lost and so potentially patients’ dental fitness was being compromised. This was also putting at risk DPHC’s commitment to deliver Project MOLAR: a treatment strategy to improve the dental health of personnel entering the military. The practice were able to show us evidence of requests for additional staff resource they had made at regional telephone conferences.

**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 Harrogate Hospital for oral surgery, orthodontic patients could be seen at RAF Leeming and restorative specialties were available at CRD Aldershot. Staff were aware of the referral protocol in place for suspected oral cancer under the national two week wait arrangements. This was initiated in 2005 by The National Institute for Health and Care Excellence (NICE) to help make sure patients were seen quickly by a specialist. One of the dentists maintained a referral log and 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 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 care 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 that treatment options were discussed with them.

Staff had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting and 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.
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 were aware of their responsibility to respect people’s diversity and human rights. We spoke with 15 patients on the day of the inspection and received written feedback from 14 patients. All suggested patients felt that they received a good standard of service. Emerging themes suggested that staff listened to them and explained what they were going to do, staff ensured that discomfort was kept minimal 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. The SDO explained how he would invite a very nervous patient for coffee before they were expected to attend an appointment in a surgery, to build rapport and trust. 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 told us that they therefore did not discuss treatment in this area. Patients could be brought through to a private area if required. 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.

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 and online.

Staff could support patients who do not speak English as a first language through a translation service.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support 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.

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.

Despite the current staff vacancies and reduced nurse and hygienist availability, the practice continued to meet any urgent patient needs swiftly. However, oral health promotion opportunities were not being maximised and so the practice’s capacity to successfully deliver Project MOLAR was compromised.

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 would need to travel to another practice 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 recorded and responded to. There had been one complaint in the last twelve months. This was a verbal complaint and we noted that it had been investigated and that the patient had been given an explanation and apology.
Are services well-led?

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 interim practice manager had the delegated responsibility for some of the day to day running of the service, but because they had been seconded in at short notice from another practice (and had not received practice manager training), they were unable to assume the full complement of practice management responsibilities. Nevertheless, staff were clear about current lines of accountability and knew who they should approach if they had an issue that needed resolving. The SDO had assumed additional accountabilities and tasks to ensure that lack of staffing capacity did not negatively impact the effective ongoing management of the practice.

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 2017 and a management action plan had been issued as a result of this visit. A review of this action plan demonstrated that the SDO had worked effectively to tackle and resolve a large number of improvement requirements successfully. The net impact was a practice with embedded safe systems and practices.

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 referred to them throughout the inspection. Effective risk management processes were in place and followed by staff and checks and audits were in place to monitor the quality of service provision.

Staff told us that there were clear lines of communication within the practice. All staff felt well supported and valued. Team meetings were held each regularly to check the workload/activity for the week and staff were encouraged to speak openly about any concerns and to provide 360-degree feedback to others. Meeting minutes were kept and made available to the staff team.
Peer review meetings were also established. Dentists met to discuss cases, particularly complex cases and to discuss the progress of clinical audits. All staff participated in peer review at the quarterly regional dental meetings and dentists attended Deanery and British Dental Association 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 dental care records were stored securely.

Leadership, openness and transparency

Staff reported that they were proud of the standard of care they provided. All 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. Staff spoke highly about the leadership of the SDO and they told us that they were willing to work hard (and sometimes additional hours) to ensure that a good standard of care was offered to patients. The practice team were delivering good clinical care to patients, but vacancies in nursing and hygiene therapist posts meant that staff sometimes worked beyond their hours to deliver the care required. Staff told us that, at times, the working environment was stressful. The SDO showed us evidence that concerns around staffing gaps had been escalated appropriately during telephone dial-ins to the regional headquarters. We were reassured that the SDO and the dental practice team had done everything they could to prompt resolution for their staffing constraints.

Staff resource and skills mix are managed and determined by the regional headquarters and we interviewed both the Principal Dental Officer and the Regional Dental Manager for DPHC (Dental) ScotNorth as part of our inspection. The Principal Dental Officer was new to the role and spoke openly with us about their personal learning curve. They acknowledged that there were nursing, receptionist and hygiene therapist staffing gaps at Harrogate Dental Centre. The regional managers demonstrated some work they were undertaking to address these staffing shortages and acknowledged some barriers to them resolving the situation swiftly. The regional team had not escalated the staff resource gaps to DPHC in order that mitigating action could be considered and regional assets had not been flexed to address some key staffing gaps.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. Radiology audits were undertaken by all clinicians and were in line with IRMER requirements. Infection control and health and safety management demonstrated that audit work in these areas had led to improvement. The SDO had undertaken an effective audit of FTAs (patients who fail to attend). In June and July 2018, 65 patients had failed to attend their appointment and, following targeted work, this number had been reduced to three patients in October 2018. This improvement trend has been sustained. Dental military targets, third molar referrals, recall intervals and the recording of consent were 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. Staff were encouraged to access websites providing dental CPD to further their professional development and clinical skillset.

Practice seeks and acts on feedback from its patients, the public and staff
A suggestion box was located in the waiting area for patients to feed comments into and this was monitored on a regular basis. Staff told us that, when manning the reception area, patients sometimes asked them how long their appointment was delayed for. As a result, a system had been introduced requiring clinical staff to advise the staff member in reception if appointments were running more than five minutes late.

A system was in place for staff to provide anonymous feedback and to suggest improved ways of working by means of a staff comments box. Staff thought that this was an effective tool.