

Abingdon Dental Centre

Dalton Barracks, Abingdon, Oxford, OX13 6JB

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Are services safe?	No action required	✓
Are services effective?	No action required	✓
Are services caring?	No action required	✓
Are services responsive?	No action required	✓
Are services well led?	No action required	✓

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Summary

About this inspection

We carried out an announced comprehensive inspection of Abingdon Dental Centre on 26 April 2022. We gathered evidence remotely and guidance and undertook a visit to the practice.

As a result of the inspection we found the practice was safe, effective, caring, responsive and well-led in accordance with CQC's inspection framework.

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

Background to this practice

Located in Oxfordshire, Abingdon Dental Centre is a two-chair practice providing a routine, preventative and emergency dental service to a military patient population of 1,620. Families are signposted to nearby dental practices. The dental centre is co-located with the medical centre within a purpose-built, single storey building shared with the Primary Care Rehabilitation Facility. In addition, entitled reservists are provided with care.

Clinics are held five days a week, Monday to Thursday 08:00-12:45 hours and 13:30-17:00, and Friday 08:00-12:30 hours. Daily emergency treatment appointments are available. Hygiene support is normally provided by the dental hygienist at Benson Dental Centre, approximately a 30 minutes' drive. Out-of-hours patients are signposted by the Duty Dental Officer of the Guard of the South West region. Secondary care support is available from the local NHS hospital trust (John Radcliffe Hospital, Oxford) for oral surgery and oral medicine and through the Defence Primary Healthcare's (DPHC) Defence Centre for Rehabilitative Dentistry and their Managed Clinical Network for other referrals.

The staff team at the time of the inspection

Senior Dental Officer (SDO) (military)	One
Civilian dental practitioner (CDP)	Two
Dental nurses (civilian)	Three
Practice manager (military)	One (acting practice manager covering maternity leave)

Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and a practice manager/dental nurse specialist advisor. A second dentist specialist advisor attended as an observer.

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 SDO, dental nurses and the acting practice manager. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We also checked the building, equipment and facilities. We also reviewed feedback from patients who were registered at the dental centre.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice effectively used the 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 understood their responsibilities for safeguarding adults.
- The required training for staff was up-to-date and they were supported with continuing professional development.
- The clinical team provided care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.

- The appointment and recall system met both patient needs and the requirements of the Chain of Command.
- Leadership at the practice was inclusive and effective. Lead roles were distributed throughout the team and rotation of duties helped maintain the skillset of staff.
- 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 were in place. Staff made changes based on lessons learnt.

Dr John Milne MBE BChD, Senior National Dental Advisor

(on behalf of CQC's Chief Inspector of Primary Medical Services and Integrated Care)

Our Findings

Are Services Safe?

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. All staff had access to the new system (known as DURALS) for reporting incidents and near misses. There was a link to the system on the practice's electronic folder (SharePoint) home page and training videos had been used to educate staff on how to report a significant event. Staff we spoke with were clear in their understanding of the types of significant events that should be reported, including near misses. This was supported by internal training. A record was maintained of all ASERs, which supported identifying a trend analysis. A total of three ASERs had been recorded in the previous 14 months. A review of these showed that each had been managed effectively and included changes made as a result. For example, a trend identified was a noise from the X-ray head that resulted in the equipment being quarantined and then replaced. Significant events were discussed at practice team meetings. Staff unable to attend could review records of discussion as minutes of these meetings were held in SharePoint. Staff were required to sign a hard copy as read if not able to attend the meeting. In addition, staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was a policy linked on SharePoint that staff had read and signed.

The Senior Dental Officer (SDO) and the acting 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). In addition, all staff were signed up to receive notifications from RHQ. The system to manage alerts included a record of discussion and actions taken. A recent example of an alert for disposable aprons had been actioned. We saw that records were maintained of alerts that did not apply or did not require any action. Relevant alerts were discussed at the monthly practice meeting and informally beforehand.

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead, supported by the Senior Medical Officer (SMO) in their absence. The SMO had completed level three safeguarding training and the SDO level two. The safeguarding policy and personnel in key roles were displayed on a noticeboard in reception. All other members of the staff team had completed level two safeguarding training. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. A follow up call was made to any patient who failed to attend an appointment. The Chain of Command was contacted when the patient was not contactable.

Clinical staff understood the duty of candour principles and this was evident in patient records when treatment provided was not in accordance with the original agreed treatment

plan. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

The dentists were always supported by a dental nurse when assessing and treating patients. There was no lone working although arrangements were in place with the medical centre and guardroom should the need arise. There was a bell in the surgery furthest from reception that could be used as a panic alarm. The other surgery was situated within audible range of the reception.

A whistleblowing policy was displayed on the staff noticeboard. Staff we spoke with demonstrated a knowledge of the whistleblowing process and had been supported with training. Staff said they would feel comfortable raising any concerns. Staff also had the option to approach the regional 'Freedom to Speak Up Champion'. Contact details were displayed in the reception area.

We looked at the practice's arrangements for the provision of a safe service. The acting practice manager demonstrated a sound knowledge of requirements in relation to risk and safety and had enrolled on role specific training (this had been postponed due to COVID-19). A risk register was maintained and reviewed annually as a minimum. We found all reviews to be in-date. A range of risk assessments were in place, including for the premises, staff and clinical care. The COVID-19 risk assessment had been reviewed and revised frequently as the restrictions had reduced. The practice was following relevant safety legislation when using needles and other sharp dental items. Needle stick injury guidance was available in each surgery.

The dentists routinely used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment and for Aerosol Generating Procedures (AGPs) due to COVID-19. Floss ligatures (to secure the dam) were used with the support of the dental nurse. A split dam was used if required.

A comprehensive business continuity plan (BCP) was in place, which set out how the service would be provided if an event occurred that impacted its operation. The plan detailed how to respond in the event of loss of key personnel, loss of electrical power, restricted access to the building and loss of essential equipment. All staff were required to complete business continuity training. The BCP included staff contact details and was exercised and updated annually to ensure effectiveness if needed for an actual event. The last exercise was carried out in June 2021 to test the response to a failure with the telephone system. A review of the exercise led to Skype lines being used as a way of providing continuity at the reception desk.

Medical emergencies

The medical emergency standard operating procedure (SOP) from Defence Primary Healthcare (DPHC) was followed. The emergency trolley was well maintained and securely stored, as were the emergency medicines. The oxygen and automated external defibrillator (AED) were checked daily. A weekly check on the medical emergency kit was undertaken and recorded by the dental nurses who had been given specific training to undertake the role. In addition, the temperature of the room in which it was stored was monitored and recorded. A review of the records and the emergency trolley demonstrated that all items were present and in-date. The stock of emergency medicines was

considered in conjunction with SOP reviews and updates. All staff were aware of medical emergency procedures 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. The team completed annual basic life support training in July 2021. Training that used simulated emergency scenarios was carried out annually and had last been carried out in July 2021 with a session on how to respond to a cardiac arrest. Formal cardiopulmonary resuscitation and AED training was completed in July 2021. Staff were aware of the signs of sepsis and a sepsis protocol was displayed in the reception area.

First aid kit, bodily fluids and mercury spillage kits were available. One of the medics from the medical centre was the appointed individual trained in first aid at work and the practice was supported by medics in close proximity.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The acting 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. Renewal of DBS checks was every three years for civilian staff and every five years for military personnel.

Monitored by the acting practice manager, a register was maintained of the registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role.

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 safety, health, environment and fire team carried out annual workplace health and safety inspections. In addition, the acting practice manager routinely undertook a six monthly health and safety inspection. The unit carried out a fire risk assessment of the premises every five years with the most recent assessment undertaken in March 2021. The practice manager of the medical centre was the building custodian and held the fire safety folder. The dental centre held a copy of the fire safety certificate which was in-date. Staff received annual fire training and an evacuation drill of the building was conducted in August 2021. This drill included a review on the effectiveness of the evacuation process and lessons learnt. Control of Substances Hazardous to Health log, risk assessments and data sheets were in place. Risk assessments were reviewed in November 2021 and all met requirements. There was a lone worker policy that included informing the co-located medical centre if any staff member was working alone. Chairside support was rotated weekly to ensure all dental nurses gained experience in all aspect of the role including clinical tasks, reception and working in the central sterilisation services department (CSSD).

DPHC had produced a standard operating procedure for the resumption of routine dentistry during the COVID-19 pandemic. The dental team demonstrated that they were adhering to the guidance in order to minimise the risk of the spread of COVID-19. Testing

for COVID-19 was undertaken by all staff. Information about the virus was displayed around the dental centre. Hand sanitiser was provided throughout the building and the practice had procured a large stock of personal protective equipment for use by both staff and patients. Clinical staff knew which AGPs presented a low or high risk depending on whether high volume suction and/or a rubber dam was used. The practice had recently moved away from using fallow periods and used high filtration masks for patients requiring the non-respiratory pathway. These patients were identified by a screening questionnaire in advance of the appointment.

The practice followed relevant safety laws when using needles and other sharp dental items. The sharps box in the surgery was labelled, dated and used appropriately.

Infection control

A dental nurse had the lead for infection prevention and control (IPC) and had completed the required training. The IPC policy and supporting protocols 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. All the staff team 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 for each section and annually for a full self-audit. Regional headquarters carried out quarterly IPC audits and headquarters annual inspections. The most recent was undertaken in November 2021 and achieved an overall compliance score of 93%.

We checked the surgery. It was clean, clutter free and met IPC standards, including the fixtures and fittings. Environmental cleaning was carried out by a contracted company twice a day including in between morning and afternoon clinics. Cleaning equipment was stored in a lockable cupboard, areas were colour coded to prevent cross-contamination, and there were visible cleaning schedules for each room. The acting practice manager carried out spot checks and fed back to the cleaning supervisor. The cleaning cupboard was tidy and well organised and staff could access it if needed in between the routine daily cleaning.

Decontamination took place in the CSSD accessible from the surgery. Sterilisation of dental instruments was undertaken in accordance with HTM 01-05. Records of validation checks were in place to monitor that the ultrasonic bath and autoclave were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were regularly cleaned with arrangements in place to check materials to ensure they were in date.

The unit safety team for the station carried out legionella risk assessments and completed monthly monitoring including water temperature checks. The practice held a copy of the risk assessment and maintained a record of temperatures from each test. Anti-retraction valves (a device that blocks any fluid from getting back into the water line) were fitted, and the practice held an in-date copy of the waterline management plan.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. The contract was held by the medical centre but the dental centre maintained their own records and completed transfer notes for waste transferred to the medical centre. Copies of consignment notes, issued by

the contractor once clinical waste was collected, were sent to the dental centre for retention. The clinical waste bin, external of the building, was locked, secured and away from public view. Waste transfer notes were married up with consignment notes weekly.

Equipment and medicines

An equipment log was maintained to keep a track of when equipment was due to be serviced. The autoclave and ultrasonic bath were in-date with their annual service schedule and appropriate checks were carried out daily, weekly and quarterly. The servicing of all other routine equipment, including clinical equipment, was in date in accordance with the manufacturer's recommendations. A land equipment audit was completed in February 2022 and recommendations made had been actioned. Portable appliance testing was undertaken annually by the acting practice manager who had completed the required training. All plugs had stickers to confirm they were in-date as of January 2022.

A manual log of prescriptions was maintained and prescriptions were sequentially numbered and stored securely. The acting practice manager conducted monthly checks of sequential serialised number sheets to maintain traceability and accountability for any missing prescriptions, and the SDO carried out annual prescription audits. Minimal medicines were held in the practice, patients obtained medicines either through the dispensary in the medical centre or outsourced to a local pharmacy. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded. The SDO carried out annual audits of prescribing. Although this is not a requirement, it is good practice and improves clinical oversight. In addition, the SDO carried out quarterly audits of controlled drugs.

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 available on SharePoint and in each surgery along with safety procedures for radiography. The Local Rules were updated in July 2021 and reviewed annually or sooner if any change in the policy was made, any change in equipment took place or if there was a change in the SDO. A copy of the Health and Safety Executive (HSE) notification was retained and the most recent radiation protection advisory visit was in May 2021.

Evidence was in place to show equipment was maintained annually, last done in December 2021. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

The dental care records for patients showed the SDO justified, graded and reported on the X-rays taken. The SDO carried out an intra-oral radiology audit every six months, the last one in February 2022. A radiology quality assurance audit was carried out six monthly, the most recent was in February 2022.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients was assessed by the dentists in line with recognised guidance, such as National Institute for Health and Care Excellence and Scottish Intercollegiate Guidelines Network guidelines. Treatment was planned and delivered in line with the basic periodontal examination - assessment of the gums and caries (tooth decay) risk assessment. The dentists referenced appropriate guidance in relation to the management of wisdom teeth, taking into account operational need.

The dentists followed appropriate guidance in relation to recall intervals between oral health reviews, which were between six and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. In addition, recall was influenced by an operational focus, including prioritising patients in readiness for rapid deployment.

We looked at patients' dental care records to corroborate our findings. The records included information about the patient's current dental needs, past treatment and medical history. The diagnosis and treatment plan for each patient was clearly recorded. Treatment options were discussed with the patient; this was recorded in the clinical notes. Patients completed a detailed medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment. The dentists followed the guidance from the British Periodontal Society around periodontal staging and grading. Records confirmed patients were recalled in a safe and timely way.

The Senior Dental Officer (SDO) discussed the downgrading of personnel in conjunction with the patient's doctor to facilitate completion of treatment. The military dental fitness targets were closely monitored by the SDO and the acting practice manager. We noted that there had been a staggered catch up programme for Category 4 patients in the last six months aided by the relaxing of COVID-19 restrictions (Category 4 patients are those who require periodic dental examinations or patients with unknown dental classification). The catch up programme was staggered following instructions from regional headquarters to prevent a compounded schedule of review dates in future.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. A dental nurse was qualified as an oral health educator and had the lead for health promotion. One of the dental nurses was named as lead for smoking cessation and had completed specific training. Dental care records showed that lifestyle habits of patients were included in the dental assessment process. The dentists provided oral hygiene advice to patients on an individual basis, including discussions about lifestyle habits, such as smoking and alcohol use. Oral health promotion leaflets were given to patients and the dental nurses maintained a health promotion area in the patient waiting area. Displays were clearly visible at the reception desk and at the time of inspection included a campaign for better oral health through diet and nutrition. At the time of inspection, there was a promotion advising of the potential dangers with having dental cosmetic surgery abroad. This initiative had educational information on food and drink

most likely to cause tooth decay and was supplemented by an additional health education board on how and when to brush your teeth.

Patients could be referred to a dental hygienist at Benson Dental Centre, approximately a 30 minutes' drive away. In response to patient feedback, the referral process to see the hygienist had been changed with the first stage of treatment (learning how to treat and maintain gum disease) being delivered by the oral hygiene nurse. This intervention had reduced waiting times to see the hygienist for stage two treatment.

The application of fluoride varnish and the use of fissure sealants were options the dentists considered if necessary. Equally, high concentration fluoride toothpaste was recommended to some patients.

The SDO described the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Staffing

The induction programme included a generic programme and induction tailored to the dental centre. The programme included protected time to complete mandatory training before work commenced.

We looked at the organisational-wide electronic system used to record and monitor staff training and confirmed most staff had undertaken the mandated training. All mandated training was in-date and certificates held for individual staff members. Dental nurses were aware of the General Dental Council (GDC) requirements and were supported to complete continued professional development (CPD) over a five-year cycle.

The dental team confirmed that the staffing establishment and skill mix was appropriate to meet the dental needs of the patient population and to maximise oral health opportunities. They were working to deliver the best level of care possible whilst adhering to the current COVID-19 restrictions and responding to short notice rapid deployment pressures.

Working with other services

The SDO confirmed patients were referred to a range of specialists in primary and secondary care for treatment the practice did not provide. The SDO followed NHS guidelines, the Index of Orthodontic Treatment Need and Managed Clinical Network parameters for referral to other services. Patients could be referred to the Queen Elizabeth Hospital Birmingham or the John Radcliffe Hospital Oxford for oral surgery, oral medicine and radiograph referrals. A spreadsheet of referrals was maintained and checked regularly. Referrals were in-date and the process of tracking continued until the referral letter was returned. Specialist services were referred through the military network including the Aldershot centre for restorative dentistry.

The practice worked closely with the medical centre in relation to patients with long-term conditions impacting dental care. In addition, the doctor reminded the patient to make a dental appointment if it was noted on their record during a consultation that a dental recall was due. The Chain of Command was informed if patients failed to attend their appointment.

The acting practice manager and SDO attended the unit health committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the practice provided an update on the dental targets and failure to attend rates.

Consent to care and treatment

Clinical staff understood the importance of obtaining and recording patient's consent to treatment. Patients were given 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 after treatment had been explained. Feedback from patients confirmed they received clear information about their treatment options.

Clinical staff had a good awareness of the Mental Capacity Act (2005) and how it applied to their patient population.

Are Services Caring?

Respect, dignity, compassion and empathy

We took into account patients' views of the service offered at Abingdon Dental Centre. The practice had conducted their own patient survey between September 2021 and March 2022 using the General Practice Assessment Questionnaire (GPAQ) feedback tool. A total of 67 patients responded and the feedback indicated a high level of satisfaction. For example, 88% of responders described staff as 'excellent' and 12% 'good' in respecting their privacy and dignity. When asked how they rated the practice at treating them with kindness and compassion, 89% responded with 'excellent' and 11% 'good'. A patient survey was arranged by the Defence Medical Services Regulator to complement this inspection. A total of 67 patients responded and 62 said they found the receptionists very helpful or fairly helpful, three patients responded with 'not applicable'.

For patients who were particularly anxious, the practice provided longer appointments and time to discuss treatment and invite any questions. Patients could also be referred for hypnosis or treatment under sedation as a final option, done by referral to the Queen Elizabeth Hospital or John Radcliffe Hospital.

The dental centre had a dedicated waiting area for patients with chairs set back from the reception desk. Since COVID-19, patients had arrived one at a time for pre-booked appointments so there had not been a need for the waiting area to be used by more than two patients attending for a dental appointment. As restrictions relaxed, chairs were positioned and the floor marked out to create a one metre spacing. Practice staff advised us that all necessary questions were asked in advance of the patient arriving (by telephone) so that conversations at the reception desk were minimised. The back entrance of the building was used so patients had to ring a number for the door to be answered.

Access to a translation service was available for patients who did not have English as their first language. Telephone interpretation was available although staff stated that they had never had to use the service largely due to the number of foreign languages spoken by members of staff. Patients were able to request a clinician of the same gender. No requests had been made but staff knew that they could refer to a nearby military dental centre. Information including health promotion displays had been translated into Nepalese.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support patients with making informed decisions about treatment choices. The dental records we looked at indicated patients were involved in the decision making.

Are Services Responsive?

Responding to and meeting patients' needs

The practice 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 concerns about their oral health. The clinical team maximised appointment times by completing as many treatments as possible for the patient during the one visit. Emergency appointments slots were available each day. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. Treatment such as routine scale and polish was being incorporated into routine check-ups to reduce the need for patients to travel. This meant that only patients with periodontal disease had to travel to see the hygienist.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in March 2022. The audit found the building met the needs of the patient population, staff and people who used the building. There was a hearing loop that staff could use situated in the medical centre, signage at the front desk in the dental centre made patients aware. The facilities included automatic doors at the entrance, visible and audible fire alarms, car parking was available close to the entrance for disabled patients and wheelchairs were available to patients if needed.

Access to the service

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed on the front door, in the practice leaflet and guardroom, and was included as part of the recorded message relayed by telephone when the practice was closed. The practice had identified a trend of appointments running behind time and following an audit, had changed the appointment schedule to reduce waiting times. An audit of instances when the clinician was running late (between July 2021 and December 2021) showed a reduction of 75%.

Concerns and complaints

The Senior Dental Officer was the lead for clinical complaints and the acting practice manager was the named contact for compliments and suggestions. Complaints were managed in accordance with the Defence Primary Healthcare (DPHC) complaints policy. The team had completed training in managing complaints, suggestions and compliments. A process was in place for managing complaints, including a complaints register for written and verbal complaints. Although no recent complaints had been received, staff were able to discuss the process to follow should it be required. The practice used SharePoint for complaints, compliments and suggestions which allowed internal and external DPHC staff to review, analyse and identify trends.

Patients were made aware of the complaints process through the practice information leaflet and a display in the practice. The practice had a box in the waiting area and a

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notice board that summarised patients requests and comments. This incorporated any actions taken by the practice as a result.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The acting practice manager had the delegated responsibility for the day-to-day administration of the service. Staff were clear about current lines of accountability and secondary roles. They knew who they should approach if they had an issue that needed resolving.

A framework of organisation-wide policies, procedures and protocols was 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 checks and audits were in place to monitor the quality of service provision.

An internal Healthcare Governance Assurance Visit (HGAV) took place in August 2021 and a management action plan was developed as a result. The HGAV assessment outcome was positive (categorised as substantial assurance in meeting the requirements). Actions identified had been completed or were in progress. A monthly governance return was completed and included performance against military dental targets, complaints, staffing levels, staff training, audit activity, the risk register and significant events. This was submitted to regional headquarters.

All staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice and gave positive comments on the teamwork. Formal practice meetings took place monthly to support the governance structure. A summary of discussion held was summarised and written up as minutes. These were made available to staff members unable to attend.

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 a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. Discussions with patients could be facilitated away from the reception desk. A reporting system was in place should a confidentiality breach occur (on the ASER system). Staff had completed the Defence Information Management Passport training, data protection training and training in the Caldicott principles.

Leadership, openness and transparency

Staff told us the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff described a supportive and collaborative culture with the SDO and acting practice manager who were said to be supportive and considerate of their views.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. The dental centre had implemented guidance set out by Defence Primary Healthcare (DPHC) around the safe return to dental care provision during the COVID-19 pandemic.

Staff received mid and end of year annual appraisal and these were up-to-date and supported by personal development plans tailored to individual staff members. Staff spoke positively about support given to complete their continued professional development in line with General Dental Council requirements. Informal and regular discussions were held with the nursing team and a formal documented process was carried out annually.

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

An ongoing patient survey was conducted and summarised each quarter. Staff were informed of feedback during meetings. The feedback had been positive and an example of improvement made in response was improved signage around the camp to provide directions to the dental centre. Staff completed the 'continuous attitude' survey and the 'people your say' survey. Results from these surveys were collated and sent out by DPHC command so staff had access to the outcomes.

The SDO listened to staff views and feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.